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JANUARY 1988, Vol. 75, No. 1

AIDS: Ad Hoc Committee Update

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JANUARY 1988, Vol. 75, No. 1

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This month's cover of *The Journal* displays a variety of informational documents on AIDS. The first article of the scientific section focuses on the activities of the Florida Medical Association's Ad Hoc Committee on AIDS, including the development of a new clinical manual on AIDS to be published for physicians and other health care professionals in Florida.

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Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

See how flexible we can be, call our Army Medical Personnel Counselor.

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Increase in PLI Activity

The new year has begun with an increase in activity regarding our PLI problem. Our proposed constitutional amendment is now before the Florida Supreme Court and we anticipate a favorable ruling by the end of January. Governor Martinez announced that the Special Session on medical malpractice will begin February 2.

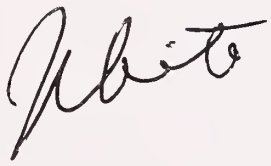
Currently 46 House members are committed to cosponsor Representative Sam Bell's MIRA bill. The Senate is expected to draft similar legislation and if all goes as planned, we could have significant laws passed by the time you read this.

The members of your Board of Governors fully realize that the MIRA bill is by no means perfect and will not please all 15,000 FMA members. We do believe, however, that this is a very good bill and is a giant step in the right direction.

We need to unify our efforts and get on with helping our legislative staff to pass MIRA.

We are going to have a "Rally in Tally" on the opening day of the Special Session. Hopefully, many physicians and/or spouses will come to Tallahassee; however, we are asking those who cannot be there to take a day off, except for emergencies, as a symbol of support for our legislative effort.

The rally will be well planned and we will make your trip as pleasurable as possible. Hope to see you soon in Tallahassee.



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The Increasing Third-Party Menace

A few years ago, it was unthinkable to tell a physician what to do with his patients, when to put them in the hospital, and how long they could stay in the hospital. Now it has become commonplace for the physician to be told all these things. Moreover, in the exercise of his clinical judgment, he may be denied payments for legitimate services to his patients. George Orwell would have been amused to find that some of his wacky predictions a few generations ago are coming home to roost.

The pervasive presence of third parties and their intrusion into the practice of medicine have become a matter of critical concern to the medical profession. Physicians are justifiably disturbed by their impaired ability to make decisions for their patients, and incensed that third parties with marginal qualifications and with no intimate knowledge of their patients are allowed to appropriate what should be the sole function of physicians. Ultimately, patients will suffer from this unwarranted interference.

Medicare with its DRGs and its state PROs is a prime example of how radically the rules have changed. Having promised elderly Americans almost everything and then failing to deliver, and being saddled with a big bill about which they were warned from the start, politicians with their usual shortsightedness have turned the tables around and have made physicians the scapegoats. The current system is riddled with bureaucratic ineptness and has been plagued by endless complaints about its primary emphasis on cutting costs at the expense of interests of patients. Of course the government does not give a hoot and pays only lip service to what is good for patients. And so does the legion of myrmidons and apologists working for it.

The system of monitoring physicians and their patients is not limited to Medicare patients. Private insurance companies have devised their own programs and have cloaked their watchdog activities under such euphemisms as pre-certification, second opinions, peer review, utilization review, and managed care. They never call them by their real name: cost containment.

As a primary care practitioner doing general internal medicine, I see numerous examples daily of how the system works and how it shortchanges both physicians and patients. If I admit to the hospital an acutely ill non-Medicare patient under a group plan, I almost always get a call from a distant insurance company about why I am admitting the patient, what I am planning for treatment, and how long the patient is going to stay in the hospital. This is followed by a second call, and a third or fourth call several days later to make sure I'm doing what they expect me to do for the patient. If my patient stays longer than expected because of unexpected problems or complications, the surrogate doctor from the insurance company makes the follow-up call, interrogates me, with an occasional heated confrontation when I disagree with his long-distance judgment. The basic flaw of the system lies right there. Why should some stranger out there with little knowledge of my patient and with absolutely no responsibility for that patient be allowed to make a judgment and interfere with what I am doing for the patient?

Taking care of hospitalized Medicare patients is even worse. Hospitals across the country have equipped their staffs with a zealous army of utilization reviewers, usually nurses who got tired of patient care, and they are on the prowl in every medical floor as soon as the admitting office buzzes them about a Medicare patient being admitted. Armed with their cookbook Bible from the HCFA, they scrutinize the charts, pore over their DRG tables, and then place tidy little notes to remind the doctor that Mrs. Schniffles is entitled to stay only for five days. Calls are made periodically telling physicians Medicare is likely to deny payment for an admission because the patient does not meet the cookbook criteria of the PRO. I have gotten such calls for a patient in acute pulmonary edema who was not on IV medications, on a patient with nausea and vomiting for five days who was on IV fluids but whose BUN and electrolytes were only slightly out of whack, and on a patient with unrelenting abdominal pain on parenteral narcotics but who was not getting them every four hours around the clock. Hospitals, of course, try to justify such overzealousness with the excuse that they need to protect their bottom lines. That may be so, but everybody also knows that most hospitals are reaping more healthy profits from DRGs than they did without them.

That is not the end of the picture. The situation is worse with that much-maligned PRO, whose forbidding shadow casts a dark spell over every physician's practice. The complaints against the PROs are well-known but they bear repeating: few on-site reviews, unqualified reviewers, too much reliance on

nonmedical personnel, excessive emphasis on costs, hidden identity of reviewers, and inability to communicate with the reviewers. A number of hospitals are now on 100% review because of their previous denial rates, and it boggles the imagination to think of the tremendous waste of time, manpower, paperwork, and money into such fishing expeditions. Along with most primary care practitioners, I receive every month an inordinate amount of mail from the state PRO, notifying me of potential denials and of a possible change in principle (sic) diagnosis. (An organization that cannot even distinguish "principal" from "principle" ought not to be trusted). The notices do not contain a reason on why these cases are being reviewed, and one can only speculate that the bureaucratic mind is at work here. When a patient's admission is denied, the appeals process takes several months, with almost no chance to communicate directly with any physician reviewer. If physicians hate the PROs, they have every reason for doing so. I can recall nothing in recent memory that has caused as much consternation among physicians as this ill-conceived monster.

And what have all these rabid watchdog activities accomplished? Very little. The most that can be said is that they may have curbed the excesses of a few marginal, incompetent, and unscrupulous physicians. The fact remains that the overwhelming majority of physicians are honest and competent. Intense review of hospital admissions also reduced medical expenses slightly, but the savings went to hospitals and other profit-making businesses, not to patients. The most telling impact, however, is in stripping away the physician's autonomy and emasculating his role in making clinical decisions for his patients. The quality of patient care inevitably gets eroded.

By whatever mechanism it is carried out, cost containment fulfills a necessary function in moderating the costs of medical care. But it should not be carried out at the expense of intimidating physicians and supplanting their judgment. Neither should it be done by sacrificing the interests of patients. The system we have now is inefficient and burdensome and it victimizes both patients and physicians. A drastic overhaul, particularly of the PRO program, is needed in favor of a system that will fulfill its role without subjugating the rights of physicians and patients alike.

Working within the system is always desirable in trying to change things around, as the AMA is attempting to do in its efforts to modify the onerous aspects of the PRO program. But far more drastic action is sometimes needed to bring about urgent reforms. One such individual who took this step is Dr. Laurie Dozier Jr., a cardiologist from Tallahassee. On October 6, 1986, one of his patients recently discharged from the hospital received a notice from the state PRO denying the hospital admission because of "substandard medical care" by the doctor. Dr. Dozier fumed at the idea that he was adjudicated guilty of substandard care without being given fundamental due process by the PRO. He sued both the HCFA and the state PRO and has spoken to various medical groups in the country in a personal crusade to revamp the PRO system. The AMA, FMA, and the American Society of Internal Medicine, among other medical groups, are solidly backing him in his efforts. Although the suit is still in progress, the state PRO has since rescinded its notice to Dr. Dozier's patient.

As we look to the future, perhaps what we need are more men with the guts and the courage of convictions of Dr. Dozier to challenge the system. If we remain silent, we will continue to be elbowed to the sidelines as powerless, helpless, and passive spectators in our own profession.

R.G. Lacsamana, M.D.
Editor

A New Perspective

By the time this editorial is read we will all know whether the special session of the Florida Legislature took any positive action in regard to the malpractice crisis which has plagued the state for the last 15 years. I, like many other physicians, have awaited anxiously for the special session to be held on February 2-4 1988. I could spend the bulk of this editorial talking about the many things that I like about the Medical Incident Recovery Act (MIRA). There are many positive aspects to this bill such as limits on noneconomic damages, arbitration, no fault in regard to neurologic impaired babies, and limits on attorneys' fees. I could fill this editorial with all the reasons that point to a rational and intellectual support of MIRA. Instead, I would like to say if MIRA is passed it will have a far more beneficial effect than just revisions of the law. It will create a new mileau in which the Legislature will be operating in for the first time. If this bill is passed, then it indeed will be a first for the Florida Legislature.

In that regard, it will create a different type of thinking and a different mind-set than existed previously. If the Legislature is able to pass a cap and provide provisions for that cap to be upheld as constitutional, then it certainly will become a part of thinking in years to come that caps on some types

of damages are acceptable. While the limit on the cap may not be all that we wish, it may be easier in future years to have a more reasonable cap adopted. It is very difficult in many cases to bring a new idea to a group of people that they are not used to and ask them to adopt it. It is often easier after the idea has been instituted in some form for adjustments to be made in the concept and creation of that idea. This I think will be the true value of MIRA in years to come. The Florida Legislature will find it much easier to discuss intelligently and to adjust caps on noneconomic damages. The Florida Legislature will have recognized for the first time also that there are some bad results in medicine which are not necessarily the fault of doctors. The no fault neurological brain damage section brings this point to the front. If this mileau is created, then it will be easier in the future for the state Legislature to look at other results to see, if indeed, there are many other aspects that are not necessarily the fault of doctors.

Just as important, the MIRA plan puts limits on attorneys' fees in malpractice cases. Once a limit is placed on attorneys fees, no matter what that limit, then in the future it will be a subject that is open to discussion and more stringent limitations can at least be reasonably entertained. Without the precedent of the first step or the principle that this is acceptable to the Florida Legislature and the people of Florida, then the next step would never be available to take.

So, although there are many aspects of MIRA which hopefully will have a positive result, I feel that just the precedent of passing many provisions of this act will encourage discussion on many subjects and will negate many of the taboos which have kept medicine and society from opening new horizons.

I think the mileau which MIRA will create is just as important as the MIRA plan itself and in years to come this mileau will create the climate for more changes in subjects that were previously considered off limits.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach

What Is Life to You?

To the preacher life's a sermon,
To the joker life's a jest,
To the miser life is money,
To the loafer life's a rest.
To the soldier life's a battle,
To the teacher life's a school.
Life's a great thing for the thinker,
But a folly to the fool.
Life is just one long vacation
To the man who loves his work,
But it's a constant dodging duty
To the everlasting shirk.
Life is what we try to make it,
Life's a story ever new:
To the faithful, earnest worker;
What, my friend, is life to you?

— Anonymous

Every life is a canvas on which the picture being painted can be drab or colorful, conventional or avant garde, a composition of exciting design, or distinguished by fine detail. But whatever form it takes, it will be unique and candid. So give yourself the satisfaction of knowing that — good or bad — it's your best. You can only paint so many hours each day, and there may be little opportunity for retouching, so give it the thought it deserves. Ask yourself whether you are leaving out details, whether the colors are lively, whether you are happy with the underlying design.

If you honestly seek to live your best at all times, that determination is visible every moment; no trifle is too insignificant to reflect this principle. No matter how uninteresting and dull the rounds of your duties, you should dignify them by your actions.

One of the most weakening elements in any individual's makeup is the surrender to the oncoming years. Self-confidence dims and dies with the fear of age. This is a false, blind closing of life to wondrous possibilities. Required are greater effort, closer attention, and deeper concentration, as the impossible does not exist for the person who is self confident and willing to pay the price in time and struggle. The most fatal illusion is the settled point of view, it obstructs progress since life is growth and motion.

Happiness is the greatest paradox; it is the hunger to give, comes from within, consists not of having but of being, not of possessing but of enjoying. It has a number of understudies — gratification, satisfaction, contentment and pleasure, clever imitators that simulate its appearance rather than emulate its method.

The basis of happiness is the love of something outside one's self. It involves optimism, faith, consecration, concentration, conquest and conscience. Every man radiates sympathy or sorrow, morbidness or cynicism, hope or happiness. If each one sets out each day to make life happier, brighter and sweeter not just for himself but for others, with a new resolution, new strength and renewed enthusiasm, then happiness would be his in its highest and best form. He will recognize happiness as a state of wellbeing characterized by relative permanence, by dominantly agreeable emotion ranging from contentment to deep and intense joy and a natural desire for its continuation.

Clyde M. Collins, M.D.
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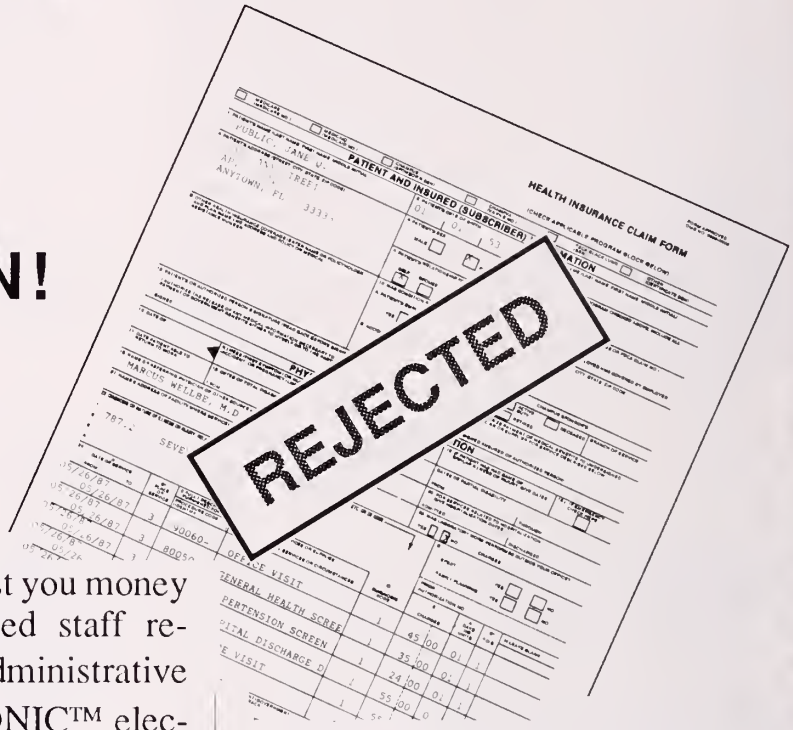

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Medical Practice Without Liability Insurance: Is It Rational and Responsible?

When I began private practice in neurosurgery in south Florida in 1981, I bought medical malpractice insurance with unlimited coverage for less than $20,000 a year. My underlying primary insurance was through a local self-insurance trust, and the "excess" coverage through the State's Patient's Compensation Fund. Of course, we now know that this ill-conceived agency collected totally unrealistic premiums for unlimited coverage. Nevertheless, it was available then. Over the next six years I saw my premiums soar and the amount of my coverage plummet. In July 1987, I was faced with a premium of over $100,000 for a claims made policy that would pay only $250,000 per incident. I decided that was no longer insurance and I would not pay for it. I have practiced without insurance since then.

My colleagues who practice in other parts of the country were amazed at my decision. Is this a rational and socially responsible position for me to take? I believe it is. The concept of insurance entails at least two principles. One is that a large group shares the loss of a few members. Another is that the amount paid in by each member (the premium) is a small sum compared to the amount for which he is protected (coverage). Malpractice insurance for high-risk specialists in south Florida fails both principles. Nearly every high-risk specialist can expect to be sued and incur loss, and the premium one pays approaches a half (possibly more if you consider the cost of the tail) of the cost of the coverage one gets. Moreover, in my specialty, multimillion dollar judgments are not uncommon. It's obvious I'm not really protected by a $250,000 policy. Is it rational to pay for it, assuming I was financially able?

How do I justify my moral and social obligation to society? Assume I make an error and my patient suffers as a consequence. In this case I can offer a settlement. The amount of money I would have paid in premiums over a few years would be a substantial amount. Not a million dollars for the attorney, to be sure, but does anyone earn that kind of money?

There is another consideration that I believe not only justifies my going bare, but also makes it a worthy cause. The courts and legislature have allowed our current system of medical malpractice proceedings to become a truly burdensome and offensive operation. It fails on all counts except for one or two. It does *not* readily and fairly compensate the "victim." It only rarely punishes the physician who practices bad medicine. It certainly does not reward the physician who practices good medicine. But it succeeds in paying the legal profession and the insurance industry. In the past ten years organized medicine in Florida has not been able to change the system in a meaningful way, despite concentrated effort. As physicians we have limited options. It's illegal to strike, and we cannot walk away from the emergency room and leave the sick and injured to die. It is presently legal to practice medicine in this state without liability insurance, provided certain conditions are met. Dropping our malpractice insurance is one of the few options we have to voice our protest.

Perhaps the legislature will deal with the medical malpractice issue in a fundamental way in a coming session, but more likely it will not. Our problem exists today — we can no longer wait. As Henry David Thoreau wrote in his essay, "Civil Disobedience," "Unjust laws exist . . . as for adopting the ways which the State has provided for remedying the evil, I know not of such ways. They take too much time, and a man's life will be gone."

Amos Stoll, M.D.
Ft. Lauderdale

Ode to the Greater Omentum

I sing, not to the lesser, lurking in the deep
and unexplored recesses,
but to you, the greater, velementous curtain,
hanging gracefully from my bowel;
tangled masses of fat and vessels, fibrous strands and
matted plaques.

To those who enter the abdominal cavity,
some with glee, others gravity,
often find you quite confusing, never, never,
never amusing.
You are not a thing of beauty, but thank God you
were on duty,
when my gallbladder, stoned, accurst,
gave up coping and just burst.
You, my friendly glob, did find the hole and plug
the leak;
preventing widespread inflammation, maybe
even my cremation.

Are you, oh greater, a real organ, with structured,
functional goal,
waiting for a "code," a rip, or hole?

Or could you just lie there and let me die there?
Stop, fearless surgeon, before you begin;
remember the young the very thin;
no greater omentum will you find, you're on your own, use heart, use mind;
get in there quick, use every trick, don't let it spread, or he'll be dead.
Were you, oh greater, built to play a part,
or just an anatomic work of art?

Courtlandt D. Berry, M.D.
Winter Park

Editor's Note: Besides gynecology and pathology, Dr. Berry is now adding classical poetry to his repertoire.

PLI: The Overriding Issue

Regarding the "If He Had Been Paying Attention" Editor's Note to orthopedist Dr. Philip Lascelle, I would offer the following: The reason orthopedists and other so-called high risk specialists in Florida consider the malpractice situation the overriding issue in this state is very simple. As Dr. Lascelle pointed out, if we are forced out of practice or out of the state because of our malpractice premium, then any other medical issue is indeed superfluous. Although other doctors are certainly sympathetic to our plight, one really needs to have the experience of paying several months gross practice revenues for their malpractice premium before the full impact of this situation is felt. I reiterate Dr. Lascelle's point. There is one and only one issue of importance at this time as far as the practice of medicine in Florida, and that is the issue of the immoral, insane and unpayable malpractice premiums faced by the high risk specialists.

Allen S. Lewis, M.D.
Sarasota

Editor's Note: Dr. Lewis, Dr. Lascelle, and I all agree on the importance of the malpractice problem. I was simply saying we ought not to straightjacket ourselves by shutting our minds off to everything else.

Have You Advised Your Smoking Patients to Quit?

I read in disbelief the April 10, 1987 article in the Journal of the American Medical Association entitled "Are Physicians Advising Smokers to Quit?" As a pulmonary physician the adverse effects of cigarette smoking on the health of my patients are readily apparent and I doubted that "only 44% of smokers reported ever having received a physician's advice to quit. In other words, 56% of smokers said they had *never* been advised to quit by a physician." Although this study was conducted in Michigan, I can't be sure it doesn't apply to Florida physicians as well.

Fortunately, the American Lung Association of Florida is making available "Clinical Opportunities for Smoking Intervention: A Guide for the Busy Physician," developed cooperatively between the National Heart, Lung and Blood Institute and the American Thoracic Society, the medical section of the American Lung Association. As stated in the Forward of the guide, "it describes how physicians can encourage patients to stop smoking in ways that are consistent with their medical practice protocol . . . and can be easily integrated into a physician's clinical setting." Those interested in obtaining a copy should contact Chris Deputy, Director, Smoking and Health Education, American Lung Association of Florida, 5526 Arlington Road, Jacksonville, FL 32239-8127, telephone (904) 743-2933.

The 1979 Surgeon General's report on smoking and health concluded that 10% to 25% of smokers may quit or reduce the amount they smoke if advised to quit by their physicians. If this is true, then by adding only one or two seconds to the routine office visit — the time it takes to say "QUIT SMOKING!" — physicians "can play a powerful role in promoting long-term nonsmoking behavior in their patients and ultimately create a healthier America." This is doubly true for the obstetrician whose preventive health measures affect both mother and fetus.

Maybe we need the following bumper sticker — FLORIDA PHYSICIANS — LET'S GET GOING! GET YOUR PATIENTS TO QUIT SMOKING!

Martin A. Cohn, M.D.
Miami Beach

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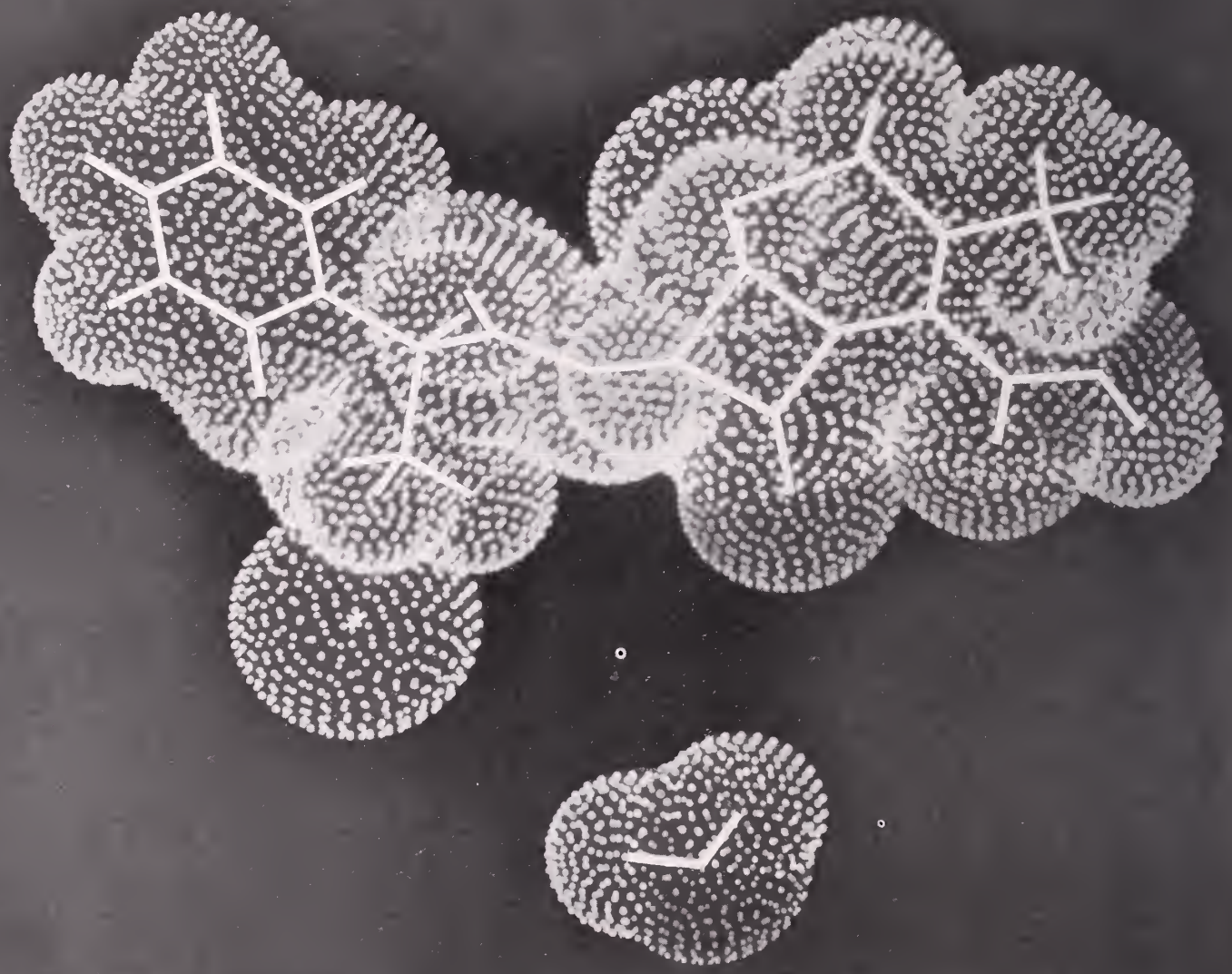

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- Safety and effectiveness in children have not been established.

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- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

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Focus on AIDS in Florida

Daniel L. Seckinger, M.D., Paul T. Harrington, M.D., and E. Russell Jackson Jr., M.A., M.P.H.

***INTRODUCTION:** The Board of Governors of the Florida Medical Association (FMA) established an Ad Hoc Committee on AIDS in June 1987 to unify the FMA's interests, concerns, and activities regarding the disease. This action has provided a focal point for input from the various FMA committees and councils and from the county medical societies and specialty groups.*

The Committee equips the FMA with a special panel to review proposals on AIDS from a variety of sources and to generate proposals of its own. Consequently, recommendations pertaining to AIDS made to the Board of Governors and House of Delegates now principally emanate from a committee composed of physicians and advisory members expert on the AIDS pandemic.

The Authors
DANIEL L. SECKINGER, M.D.
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Dr. Seckinger is Chairman of the FMA Ad Hoc Committee on AIDS, Dr. Harrington is Chairman of the Editorial Subcommittee of the Ad Hoc Committee on AIDS, and Mr. Jackson is FMA Director of Medical Services and Scientific Activities.

Formation and meetings of the Ad Hoc Committee on AIDS ● FMA President James B. Perry, M.D., appointed the members of the Ad Hoc Committee on AIDS, naming as chairman Daniel L. Seckinger Jr., M.D., a Miami pathologist. Other members are experts in the fields of pathology, infectious diseases, family practice, internal medicine, pediatrics, general surgery, addictionology, preventative medicine and public health. The current FMA President, James G. White, M.D., reappointed the committee members with Dr. Seckinger as chairman, and also apointed additional members.[1]

The Committee was organizationally placed within the Council on Medical Services chaired by Joseph T. Ostroski, M.D., a Miami general surgeon. Dr. Ostroski is responsible for presenting recommendations of the Committee to the Board of Governors; accordingly he has attended all meetings and actively participated in deliberations.

The Committee's initial organizational meeting was held on August 11, 1987. At that time the members developed a mission statement which reads:

> The purpose of the Ad Hoc Committee on AIDS is to recommend policy positions and actions which the FMA should undertake with regard to AIDS based upon the best scientific knowledge and medical judgment available.
>
> Its mission in developing such policy and action recommendations is to work closely with the Governor's Task Force on AIDS, the AMA, and other appropriate federal, state and local agencies and organizations in order to increase the public's awareness and ability to prevent the incidence of AIDS and its spread among the general population.
>
> The FMA Ad Hoc Committee on AIDS

accordingly will be involved in educating physicians and other health care professionals, as well as the general population, and those segments of the population at greatest risk, in order to protect and promote the public's health.

And further, its mission is to develop to the extent feasible agreed upon positions with respect to AIDS so that organized medicine and individual practitioners can speak in unison and authoritatively on this subject.

At its September 28, 1987 meeting, the Committee made recommendations on several issues which were conveyed to the Board of Governors at its Fall Meeting. The Board of Governors approved these recommendations:

Clinical Manual on AIDS: The FMA will prepare, publish and distribute to physicians, and other appropriate health groups to be identified, a physician clinical manual on AIDS; further, the FMA will accept financial responsibility for publishing the manual in an amount up to $25,000, and further, the FMA will seek financial support for publication of the manual from other organizations, including block grants from the U.S. Department of Health and Human Services and the Florida Department of Health and Rehabilitative Services.

General Public AIDS Document: The FMA will prepare and endorse a document entitled "What You Must Know About AIDS" as an informational document to be made available to the general public and encourage HRS to provide for its general distribution throughout the state of Florida.

AMA AIDS Policies: The FMA will adopt AMA policy recommendations on AIDS as approved by the AMA House of Delegates in Report YY, "Prevention and Control of AIDS," to serve as general policy positions for the FMA with regard to AIDS in Florida. In recommending the adoption of Report YY, the Board agreed with the Ad Hoc Committee on AIDS recommendation that the reporting of individuals with AIDS seropositive tests should be required by Florida law; and further, that by recommending the adoption of Report YY, the Board concurred with the Ad Hoc Committee on AIDS to support necessary action to implement the recommended policies contained in Report YY, and referred Report YY to the FMA Council on Legislation.

AIDS in Florida's Prisons: The FMA will assist the Florida Correctional Medical Authority in the development of a paper to be submitted to the Governor and the Legislature by the Correctional Medical Authority in December 1987 dealing with options on the testing, education, confidentially, and isolation relating to AIDS in Florida's prison system.

The Ad Hoc Committee on AIDS met again on November 4, 1987. Representatives of the Florida Osteopathic Medical Association, Florida Dental Association, Florida Nurses Association, and Florida Hospital Association were invited and made presentations specific to concerns of their associations and the professions and institutions which they represent. Upon nomination from these associations, Dr. White named a representative from each one to serve as an advisory member to the Ad Hoc Committee on AIDS.

Committee activities ● By request, Dr. Seckinger made presentations in 1987 regarding such issues as AIDS testing, confidentiality, and physician availability to the Senate Committee on Education and the House Health Care Committee Task Force on AIDS. Additionally, he represented the FMA before President Reagan's Commission on the HIV Epidemic as well as the Florida Statewide Health Council. Dr. Ostroski represented the FMA at the Senate's Select Committee on AIDS meeting in January 1988. Other members of the Ad Hoc Committee on AIDS are involved with the Governor's AIDS Task Force; Education Commissioner Betty Castor's Task Force on AIDS; and a variety of similar national, state, and local governmental entitites and associations. In December 1987, the FMA submitted to the Florida Correctional Medical Authority a 25-page report with recommendations entitled "AIDS in Florida's Prison System."

The Committee is developing two major educational documents: a Clinical Manual on AIDS for use by physicians and allied health professionals; and a General Public AIDS Educational Document. This activity is coordinated with the State Health Office of the Florida Department of Health and Rehabilitative Services (HRS), AMA, and U.S. Department of Health and Human Services, principally through the office of the Assistant Secretary for Health, Robert E. Windom, M.D., a former FMA President from Sarasota.

The State Health Office has committed approximately $50,000 to assist the FMA with the Clinical Manual on AIDS, which is to be made available to physicians and allied health professionals in Florida. Further, the State Health Office agreed to distribute the General Public AIDS Educational Document statewide.

Clinical Manual on AIDS ● In response to the recognized need to better inform physicians and other health care professionals about AIDS, the Ad Hoc Committee established an Editorial Subcommittee to develop a Clinical Manual. Dr. Seckinger appointed Paul T. Harrington, M.D., a Jacksonville internist and expert on infectious diseases, to serve as chairman. This Subcommittee met on January 11, 1988, approved a proposed outline and assigned to members of the Ad Hoc Committee responsibility for writing various components of the manual. A preliminary draft is expected to be ready for review by early March 1988.

Major sections of the manual include: Natural History of HIV Infection; Classification of HIV Infection, Tests for HIV Infection; Clinical Manifestations:

Evaluation, Diagnosis and Management; Specific Therapy for HIV Infection and Immunodeficiency; Special Issues, such as AIDS in the workplace for health care providers; AIDS in Florida; Legal, Ethical, and Legislative Issues; FMA AIDS Policy; and Resources, to include listings of state and local AIDS programs and referral mechanisms.

The manual will contain original material based upon the best knowledge available specific to AIDS in Florida; the expertise of the Committee members; and other contributors from the scientific and academic communities. It is to be contained in a hardback notebook which will allow easy replacement of pages for updates and other additions as more knowledge is acquired.

Prospects for the future ● Florida has consistently ranked third in the nation in the cumulative number of reported cases of AIDS. The United States cumulative case count by November 1987 was 44,757 and Florida numbered 3,302 or approximately 7% of the nationwide count.[2]

HRS has maintained surveillance of the AIDS epidemic in Florida since 1981. Projections by the State Health Office in February 1987 indicate that the cumulative case count will continue to double approximately every 12 to 15 months; therefore as many as 4,000 cases can be expected by 1988; 8,000 by 1989; 16,000 by 1990; and 32,000 by 1991.[3]

The human immunodeficiency virus (HIV) is slow to claim its host. Persons infected may show no signs or symptoms for five to seven years on the average, and up to ten years or more in some cases. Consequently, most persons in Florida and the nation who will be diagnosed with AIDS between now and 1991 are already infected.[4]

Persons with AIDS represent only a fraction of the problems associated with the epidemic. The Centers for Disease Control (CDC) estimates that an even larger number of persons are infected with the virus and currently show no signs or symptoms of illness. CDC estimates that 50 HIV infections exist for each reported case; in Florida, that translates to more than 145,000 persons infected as of November 3, 1987.

The AIDS epidemic, because of its complexity and finality, has already proven to be among the greatest challenges to our collective medical wisdom. Until such time as a cure and immunization is found, the private and public sectors of medicine must work intricately together on this disease. This much the FMA has accomplished through its Ad Hoc Committee on AIDS and its planned activities with state, local, and federal government, as well as with other allied professional and voluntary health organizations.

The activities of the Committee, including the Clinical Manual and other educational material being developed, are consistent with the key leadership role that organized medicine must fill on behalf of society whenever medical expertise is the only hope that mankind has in the battle against disease. The FMA thus has focused its attentions and future activities with respect to AIDS on preventing the disease, prolonging life, and promoting health through organized community effort. To be successful, the FMA, its component county medical societies, and the various medical and surgical specialty groups, must proceed in concert through coordinated and concentrated activity. The FMA's Ad Hoc Committee on AIDS provides an excellent vehicle for this purpose, and it welcomes the input of all who are interested in combating the life-threatening challenges which AIDS presents to all Floridians.

References

1. The membership of the Ad Hoc Committee on AIDS: Daniel L. Seckinger Jr., M.D., Chairman, Miami; Joseph T. Ostroski, M.D., Chairman, Council on Medical Services, Miami; E. Joan Barice, M.D., Palm Beach Gardens; David G. Droller, M.D., Ft. Lauderdale; Joseph E. Dorsey, M.D., Hollywood; John E. Eustace, M.D., Miami Beach; Paul T. Harrington, M.D., Jacksonville; James T. Howell, M.D., West Palm Beach; Donald S. Kwalick, M.D., Tampa; Linda A. Marraccini, M.D., South Miami; E. Charlton Prather, M.D., Tallahassee; Gerold L. Schiebler, M.D., Gainesville; A. Lewis Leo, D.D.S., Gainesville; Barbara Russell, R.N., Florida Nurses Association, Miami; Richard Eicher, D.O., Florida Osteopathic Medical Association, Seminole; Robert S. Hart, D.D.S., Florida Dental Association, Tampa; and Patrick H. Haines, Florida Hospital Association, Orlando.
2. Florida Department of Health and Rehabilitative Services. Testimony before House HRS Committee by E. Charlton Prather, M.D., M.P.H., Acting State Health Officer, November 3, 1987.
3. Ibid
4. Ibid
5. Ibid

● Dr. Seckinger, P.O. Box 2411, Jacksonville, Florida 32203.

Estrogen Receptors in Breast Cancer

J. Todd Meredith, M.D., R. Craig McBride, M.D., and Lizardo Cerezo, M.D.

ABSTRACT: Breast cancer is the most common malignancy in women, and hormonal manipulation based on estrogen receptor status remains a mainstay of therapy. This article reviews the development of endocrine therapy in breast cancer and the available methods for determining estrogen receptor status in the clinical laboratory. A relatively new method, utilizing monoclonal technology, is that of immunocytochemical analysis. It can be performed on tissue sections or suspensions and, though only semiquantitative, has been shown to correlate well qualitatively with standard methods. A small study was undertaken to determine the feasibility of utilizing this technique in a community hospital setting. The method is relatively easy to perform and the procedure could be implemented in most histology laboratories with very little difficulty. However the primary utility is in the analysis of small samples otherwise insufficient for standard methods.

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Breast cancer is the most common malignancy in women. For every 100,000 females, 92 new cases are diagnosed annually, a prevalence of 100 per 100,000 females in any given year. Overall breast cancer will strike one of every 11 females in the United States at some time during their life. In the United States, breast cancer accounts for 27% of all female cancers and 18% of cancer deaths.[1]

It has been known for some time that several forms of cancer are hormonally dependent. This was first realized in 1896 when Beatson[2] reported the regression of an inoperable breast carcinoma after ovariectomy in two postmenopausal females. The acceptance of hormonal treatment of breast cancer came in the 1950s with the introduction of adrenalectomy by Huggins and Bergenstal[3] and of hypophysectomy by Luft and Olivecrona[4] for metastatic breast cancer in postmenopausal women. By 1960s endrocrine therapy had become the preferred treatment of women with advanced breast cancer; however, it was noted that only 25-30% of all patients so treated showed any response. This led directly to interest in measurement of steroid receptors in cancerous tissue in an effort to predict which patients would respond best to endocrine therapy and which needed other treatment modalities. By early 1961 Folca et al[5] had demonstrated that patients who subsequently benefitted from ablative surgery had tumors which showed preferential uptake of tritiated estrogen in vivo. In 1970 Jensen[6] provided the first in vitro assay to show good correlation with patient response to endocrine ablative surgery. The method utilized fresh tissue incubated with tritiated estradiol in the presence and absence of an inhibitor of specific uptake.[7] Following this initial indication of a "receptor" for estrogen which seemed to correlate with clinical responsiveness to endocrine manipulation, many other

groups[8-11] soon confirmed that knowledge of estrogen receptor status was important for proper management. Since that time it has been shown that patients with receptor-positive tumors have better objective clinical responses, including tumor regression after adjuvant hormone therapy or endocrine ablation, whereas patients with tumors lacking estrogren receptors have almost no benefit from endocrine therapy. Increased recurrence rates and decreased survival are also noted for estrogen negative breast carcinomas, while there is increased disease free survival among those with estrogen receptor positive tumors.

In conjunction with these clinical studies on estrogen receptors, basic research on steroid hormone receptors themselves was advancing. To classify as a receptor, certain features must be met: (1) binding must be specific, (2) binding must be inhibitable by analogues of the ligand to which binding is specific, (3) binding must be saturable, and (4) binding must be of high affinity.

In 1966 Toft and Gorski[12] introduced a sedimentation analytical method for the study of receptors. With this method they demonstrated that all the tissue estrogen receptor protein in experimental rat uterus tissue could be localized to the supernatant or cytosolic portion. Upon incubation this portion underwent a temperature and estrogen dependent change in its sedimentation characteristics to become a complex identical to that of a receptor complex found in the nuclei of estrogen treated rats. This led to an initial hypothesis of the estrogen receptor pathway in target cells.[13,14] Essentially a cytosolic estrogen receptor (basically an intracellular protein) takes up estrogen from the plasma and transports it to the nucleus where it binds to the nonhistone portion of the chromosome and subsequently induces protein synthesis and affects cellular division. Additional work seems to indicate that instead of a single "receptor" there are perhaps three, each with differing affinities for estrogen.[15-18] The type I receptor which is also known as estrophilin, and is probably the "true" receptor, is present in low concentration but has the greatest affinity for estrogen, being essentially saturated at estrogen concentrations of 10-9 M. Type II receptors are most likely a different group of proteins found in the nucleus and cytoplasm which while present in large amounts do not become saturated until the concentration of estrogen approaches 10-7 M. Type III receptors, which are the most abundant, are most likely composed of soluble molecules like albumin and some membrane molecules, have low affinity such that binding does not occur until concentrations of estrogen are considerably in excess of 10-7 M. Even further detailed analysis of estrogen receptors by sedimentation methods has suggested that there are perhaps ten different isoforms (distinct molecular forms) and that the correct complement of these isoforms must be present in order to effect physiological changes in cells exposed to estrogen.[19]

Steroid binding assays. ● Of the various methods of analysis that have been developed over the years, only the biochemical or steroid binding assays have the attribute of being able to meet all four requirements of a receptor. As such, they have become the "standard" to which all other methods are subsequently compared. Added to this is the fact that these methods have shown good clinical correlation to patient responsiveness to hormonal therapy. Of the two steroid binding assays in common usage (the sucrose density gradient method and the charcoal coated dextran method followed by Scatchard plot analysis) the latter appears to be the more popular. In this latter method, fresh or rapidly frozen tumor is converted into a water-soluble extract (cytosol) and incubated with various concentrations of radiolabled estradiol. The unbound estrogen is absorbed by charcoal and the bound hormone is measured by liquid scintillation counting. From this, the approximate quantity of estrogen receptor is calculated using Scatchard plot analysis.

While this remains the standard method, the process has several features which the surgeon/oncologist/pathologist find somewhat undesirable. These methods are labor intensive, require special equipment and reagents for their performance and as such are restricted to a few large centers or commercial labs. The receptors are relatively labile with a half life varying from 30 minutes to about six hours. As such it is recommended that tissue be frozen within 30 to 45 minutes of surgery and maintained on ice or in refrigeration in the interim. In fact, the NIH Consensus Development Conference[20,21] recommends storage at −70°C or colder if the assay is not performed on the day of surgery. A significant quantity of tumor, 200-500 mg, is required to perform these studies. Also an important consideration is that the results depend to some extent on the presence or absence of endogenous estrogens in the patients plasma. These can influence the number of available binding sites on the receptor protein. This may in part explain the observation that the incidence and concentration of estrogen receptors in breast tumors are lower in premenopausal as compared to postmenopausal women.[22-25] Added to this is the problem of tumor cell heterogenity, accounting for the fact that assays on the same tumor may vary from lab to lab or even within the same lab. Studies have also shown a poor correlation between quantity of estrogen receptor as determined by these methods and the relative proportion of tumor epithelium.

It has been shown that some lesions with less than 25% tumor epithelium have exhibited very high estrogen binding capacities and, conversely, others have shown that different tumors with approximately equal tumor epithelium have had widely variable

estrogen binding capacities.[22,26] While many investigators[27-29] feel that quantitation of hormone receptors are of value in prognostication, it has not been definitely shown that such quantitative values beyond a defined minimum are helpful in selecting treatment options. Thus, it appears adequate at present to know if the tumor is positive or negative for estrogen receptors since many studies confirm that positivity by these biochemical methods correlate with patient clinical response to hormonal manipulation.[30-32]

In an effort to overcome some of the negative features of the steroid binding assays, other methods have been developed. Among these are the cytochemical and histochemical methods. While many different variations have been developed, they basically all use estradiol conjugated directly or through bovine serum albumin to flourescein[33,34] while one group has utilized a peroxidase linkage.[35] These methods have the advantage of being more generally available and requiring only minimal special equipment. They also have reduced cost and decreased turn-around time. However, as explained by Chamness et al[15] the purity of the labeled estradiol is not always satisfactory, i.e.,contamination by unlabeled estradiol, which leads to a decreased level of receptor. Also the concentration of labeled estradiol used in most of the studies to date has been of such magnitude that the type II receptors are being measured rather than the true type I receptor. Additionally, the studies by Lee[34] and Panko[36] found no correlation with estrogen levels as determined by standard means. Finally McCarty[37] studied the histochemical receptor level correlation with the patient clinical response to hormone therapy. He found that the predictive value of three different histochemical methods approximated that expected by chance alone. Conversely, Masood and Johnson[38] have utilized flouresceinated estrogen ligands and progesteron ligands on imprints of human breast carcinomas for the detection of receptors. In their hands, they found 92% sensitivity and 88% specificity as compared to standard biochemical assay of charcoal coated dextran. They noted little correlation between percent of flourescent tumor cells and the quantitative value on biochemical tests. They felt the procedure reliable and advantageous in that it was less expensive and was relatively easy to perform taking about four hours of time. They suggest that the method has utility in evaluation of tissue obtained via fine needle aspiration and from pleural effusions, ascites fluid and other fluids which might become infiltrated by tumor.

Closely related to the histochemical methods are several immunochemical and immunocytochemical methods. These have been developed following the application of the hybridoma technique to the production of large quantities of monoclonal antibodies against the estrogen receptor.[39]

Immunochemical methods ● The immunochemical methods were first reported by Nenci et al[40,41] and by Pertschuk et al[40,43] who used flourescence methods, followed by immunoperoxidase methods by Ghosh et al,[44] Kurzon and Sternberger[45] and Walker.[35] These methods involve several steps. Usually there is an initial incubation of tissue with estradiol followed by washings and then reaction with antiestradiol antibody. This is subsequently reacted with either flourescein labeled anti-IgG or with an unlabeled antibody which can bind to a peroxidase-antiperoxidase complex to produce a colored reaction. With these methods it has been possible to develop both an immunoradiometric assay (IRMA) or an enzyme linked immunoassay (ELIZA). In both of these circumstances, a polystyrene bead is coated with an antiestrophilin monoclonal antibody. A homogenate of the tissue sample is then added and incubated at which time the tissue receptor adsorbs to the antibody, thus immobilizing the receptor on the bead. Following several washings, a second labeled monoclonal antibody is added for which the IRMA is labeled with I-125 and for ELIZA with peroxidase. These techniques have several advantages including relative ease of performance, no special equipment requirements, easily managed quality control and, since they are immunological methods, they do not require the presence of functional units, thus eliminating in large part the problem of labile receptor sites. Despite good correlation with sucrose density gradient values,[46,47] Chamness et al[15] report several points of concern. They question the availability of receptor bound estradiol to antibody, the concentration of estradiol necessary to visualize the response and the ability of other ligands to compete for the visualized estradiol binding. Additionally, since the process still uses a tissue homogenate, it does not address itself to the potential problem of tumor heterogenity.

Immunocytochemical analysis ● A new process which will hopefully overcome many of these problems is that of immunocytochemical analysis, a process which is commercially available (Abbott Monoclonal ER-ICA). While this method requires the use of frozen fixed tissue, it offers several advantages. It is relatively easy to perform, permanent, and makes possible the evaluation of tissue or tumor heterogenity since the histology of the specimen can be seen and assessed at the time of estrogen receptor determination. As it is an immunologic procedure, the problem of receptor lability is minimized.

The immunocytochemical test is relatively straightforward. It is based on direct antigenic recognition of the receptor protein by monoclonal antibodies rather than on steroid-binding activity. Such specificity of the antibody allows detection of the receptor regardless of the presence of estrogens or antiestrogens and thus eliminates interference by other steroid-binding proteins. At the time of tumor biopsy,

basically the tissue is frozen and two separate microscope slides are made. The slides are fixed in formalin, methanol and acetone and treated with a blocking reagent to prevent nonspecific binding of subsequent reagents. One of the two slides is incubated with the primary antibody, a monoclonal (rat) antibody to human estrogen receptor, and the other is incubated with the control antibody, normal rat IgG. These are then incubated with a bridging antibody, a goat anti-rat Ig immunoglobulin, which binds to rat antibody against human estrogen receptor in the specimen treated with the primary antibody and to normal rat IgG bound to the specimen treated with control antibody. The rat PAP complex is added to each specimen and binds to the anti-rat Ig bridging antibody. A chromogen-substrate solution of hydrogen peroxide and DAB (diaminobenzidine-r-HCL) is added to each specimen. The reaction of peroxidase with hydrogen peroxide converts the DAB to an insoluble reddish-brown product thus making the estrogen receptor visible.

While this process is relatively simple, there has been great interest in modifying the process for use with routinely processed paraffin fixed tissue. Poulsen et al[48] were able to obtain reproducible results with paraffin embedded, Bouin's fixed tissue while Shimada et al[49] obtained good results in cold formalin-fixed paraffin tissue. Andersen et al[50] have further modified the ER-ICA method using biotin-conjugated goat anti-rat IgG and avidin plus biotinylated peroxidase and found good nuclear and cytoplasmic staining with routinely formalin fixed paraffin embedded tissue. Also, Shintaku and Said[51] have utilized a DNase pretreatment of routinely processed formalin fixed paraffin sections and have noted a reliable and reproducible alternative which showed very good statistical agreement with values obtained via standard dextran coated charcoal methods. In many institutions the initial evaluation of a breast mass, or suspected metastasis from a known breast carcinoma is by find needle aspiration. Accordingly, Flowers et al[52] have described a method whereby the immunocytochemical method using commercially available monoclonal estrogen receptor antibodies can be applied to cytological preparations. While they admit to some difficulties, they do describe good correlation with the standard biochemical methods to the extent of having 80% sensitivity and 89% specificity.

ER-ICA method ● Numerous studies have evaluated both a comparison of the ER-ICA results with standard sucrose density gradient methods and dextran coated charcoal methods as well as to assess their correlation with patient clinical responsiveness to hormonal therapy.[53-59] All of these studies are in general agreement that the monoclonal antibody method of analysis of estrogen receptors shows a great specificity and sensitivity when compared qualitatively to the more standard biochemical methods. These studies confirmed that the major area of estrogen receptor staining by immunocytochemical methods is nuclear, that the ER-ICA technique is useful in predicting outcome of endocrine therapy in metastatic carcinoma, that the ER-ICA method has excellent promise for small samples of tissue such as might be obtained from fine needle aspiration or even on body fluids such as ascites, CSF, pleural effusions or pericardial fluid. ER-ICA is the most reliable method for estrogen receptor detection since it correlated in 92.9% of cases with the presence of estrogen receptor by biochemical assay and ER-ICA is a viable means of screening tumors which are reported as negative by standard biochemical methods. This has become a potentially vital aspect of receptor assessment. Due to tumor heterogenity, it is entirely possible that the specimen forwarded to a reference lab for biochemical analysis may not contain functionally active receptor or could be so contaminated by normal breast tissue or fat as to give a falsely low value. With the ER-ICA method, the tumor cellularity can be assessed and the presence of antigenically reactive receptors determined in an area which is undeniably carcinoma.

A drawback to the method is that it is only semi-quantitative. Many groups have devised scoring methods for analysis of ER-ICA specimens which basically include some assessment of cellularity and intensity of staining. McCarty et al[54] recently reported a correlative study using an immunohistochemical method and a quantitative biochemical assay. Using a scoring method of their design, they were able to demonstrate good correlation with the standard methods. He found that cellularity of the tissue specimen did not correlate with estrogen levels in this method of scoring. It must be recalled, however, that at the present time, the absolute value of the biochemical score has virtually no practical use. The only important part is whether or not the tumor has a value of estrogen receptor exceeding an arbitrarily set lower limit of clinical responsiveness which is usually in the range of 8-10 femtomoles. Perhaps at some time in the future, the level of the response will be of significant value is planning therapy.

With this information in mind, we decided to undertake a small study in our community hospital to assess the feasibility of using the ER-ICA method.

Method ● Sixteen randomly selected breast carcinomas diagnosed by frozen section analysis of biopsy tissue were utilized for both the biochemical and immunoperoxidase studies. All specimens had a cubic centimeter of tissue frozen and submitted to a reference laboratory (American Medical Labs) for biochemical determination (dextran coated charcoal) of estrogen and progesterone. At the time of frozen section, four additional sections were cut and adhered to glass slides using a tissue adhesive. These were

Table 1.

CASE	INTENSITY			CELLULARITY			PERCENT POSITIVE			REACTIVITY			ASSAY
	I 1	I 2	I 3	C 1	C 2	C 3	P 1	P 2	P 3	R 1	R 2	R 3	
1	0	0	0							0	0	0	0
2	0	0	0							0	0	0	0
3	0	0	0							0	0	0	0
4	1	1	1	3	3	3	2	1	2	6	5	6	44
5	2	1	1	2	3	2	1	1	1	5	5	4	17
6	3	3	3	2	3	2	3	2	3	8	8	8	148
7	3	3	3	2	2	2	3	3	3	8	8	8	162
8	0	0	0							0	0	0	0
9	3	3	3	3	2	3	3	2	3	9	7	9	204
10	2	2	3	2	2	2	2	2	2	6	6	7	84
11	1	2	2	3	2	3	3	2	2	7	6	7	496
12	2	2	3	2	2	2	2	2	2	6	6	7	41
13	1	1	1	3	2	2	2	1	2	6	4	5	427
14	0	0	0							0	0	0	0
15	1	1	2	1	2	1	1	1	1	3	4	4	37
16	2	2	2	2	2	3	3	2	2	7	6	7	111

Intensity: Average staining intensity among positive staining tumor cells.
0=negative, 3=strongest staining (equivalent to control stain.)

% Positive Cells: Proportion of tumor cells staining for estrogen receptor.
0 to 33%=1, 34-66%=2, 67-100%=3

Cellularity: Estimate of the proportion of the surface area occupied by tumor cells.
0 to 33%=1, 34-66%=2, 67-100%=3

immediately placed in a 3.7% formaldehyde-PBS solution for 10-15 minutes, then in a PBS bath for an additional 4-6 minutes. Following this, the specimens were placed in cold methanol at −10° to −25°C for 3-5 minutes, then transferred to cold acetone at −10° to −25°C for 1-3 minutes. After two rinses in room temperature PBS, the slides were stored at −10° to −20°C in specimen storage medium until four cases were collected (Figs. 1-4). The actual immunoperoxidase staining procedure was performed on groups of four cases following the directions of the manufacturer (Abbott).

Scoring ● Biochemical assays were reported as femtomoles of estrogen binding per milligram of cytosol protein. A value above eight femtomoles is generally considered hormonally responsive.

The monoclonal immunoperoxidase method was scored independently by us using a semiquantitative scoring technique (Table 1). A scale of one to three was used to evaluate the parameters of intensity of staining, tumor cellularity, and percentage of positively staining tumor cells. A reactivity score was obtained by summation of the results for the three parameters in each case.

Results ● The results are summarized in Table 1. Of the 16 cases submitted, 11 had an elevated biochemical level of estrogen receptor, i.e., above eight femtomoles. All five specimens nonreactive by the biochemical methods were also judged by the three examiners to be negative with the immunoperoxidase method. They were in agreement with the intensity of staining of six of the 11 positively staining cases, while two of the three observers were in agreement in the other five cases. In no instance was there a major

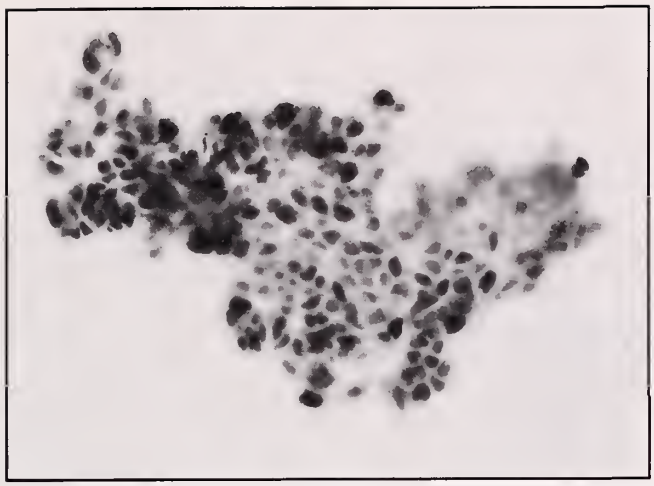

Fig. 1

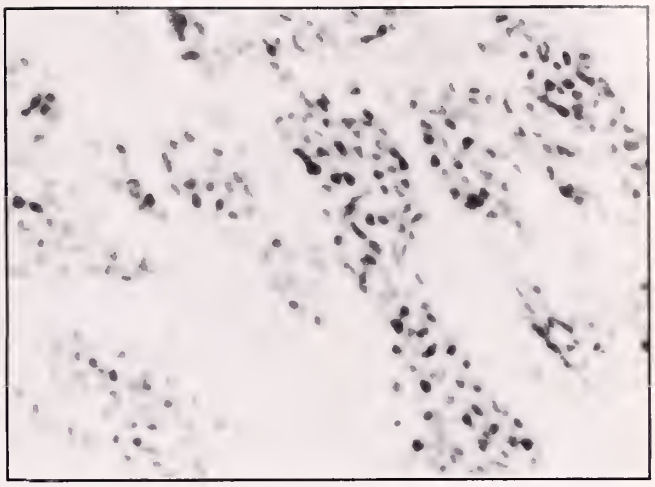

Fig. 2

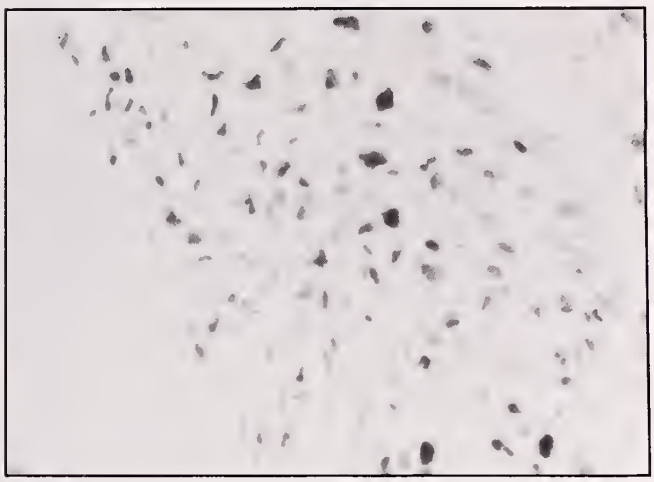

Fig. 3

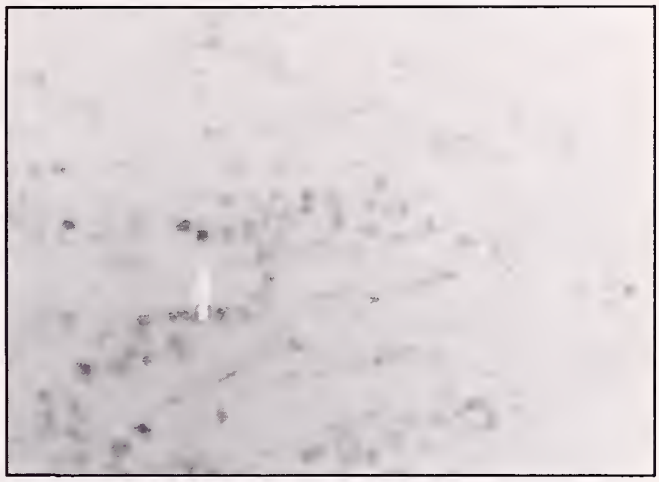

Fig. 4

disagreement in scoring. Of primary importance was the finding of no false positive or negative results with the immunoperoxidase method. However, there seems to be little correlation between the biochemical level in femtomoles and the intensity or percentage of staining cells in any given case. For example, the case with the highest biochemical level of 496 femtomoles was rated for intensity as 1,2,2 and for percent positive staining cells as 3,2,2 by the three examiners, while a case with a biochemical score of 162 femtomoles was rated as 3,3,3 and 3,3,3 respectively. The reactivity scores obtained by combining all parameters also showed little correlation (R=0.29).

Conclusion ● Evaluation of estrogen receptor status of breast carcinomas is important in the evaluation and treatment of patients. Many methods are currently available for such measurement, however, the accepted method is that of biochemical assay by either the dextran coated charcoal or sucrose density gradient methods. The development of monoclonal antibodies to estrogen receptors has made it possible to now directly evaluate the presence of estrogen receptors in a tissue section or in cell suspensions. The reliability, utility, and correlation of such a method with the standard biochemical method has been confirmed by previous studies and our own experience with the method confirms that the technique can be readily applied in the community hospital setting with very little difficulty. Our experience confirms the observation of others that there is often little correlation with the amount of tumor epithelium and the result of biochemical levels, and that there is considerable heterogenity in distribution and amount of staining both in tumors from different patients and in differing areas of a single tumor.

With the recent advances in application of the method to routinely fixed paraffin embedded tissue and fine needle aspirates or cytology preparations, the method will become increasingly more common in the community hospital. Despite this, it is generally felt that the standard biochemical methods are not to be abandoned. The new immunocytochemical method presently finds its use primarily restricted to

those instances where there is insufficient tissue available for the standard test and perhaps for evaluation of those biochemically negative cases in which there may have been borderline tissue available or contamination with fibrosis or normal breast tissue.

References

1. Clinical Oncology, Multidisciplinary Approach, 6th ed., Philip Rubin, M.D. (ed.), American Cancer Society, Chapter 12, Breast Cancer, pp. 120-140, 1983.
2. Beatson, G.T.: On Treatment of Inoperable Cases of Carcinoma of the Mamma: Suggestions for New Method of Treatment with Illustrated Cases, Lancet 2:104-107, 1896.
3. Huggins, C. and Bergenstal, D.M.: Inhibition of Human Mammary and Prostatic Cancer by Adrenalectomy, Cancer Research 12:134-141, 1952.
4. Luft, R.; Olivecrona, H.; Ikkos, D., et al: Hypophysectomy in Management of Metastatic Carcinoma of Breast. In Currie, A. (ed.): Endocrine Aspects of Breast Cancer; Proceeding of Conference Held at University of Glasgow, Edinburgh, Livingston, pp. 27-35, 1958.
5. Folca, P.J.; Glascock, R.F., and Irvine, W.T.: Studies with Tritium Labeled Hexoestrol in Advanced Breast Cancer, Lancet II:796-798, 1961.
6. Jensen, E.V.: Pattern of Hormone-Receptor Interactions. In Griffiths, K. and Pierrepoint, C.G. (eds.): Some Aspects of Aetiology and Biochemistry of Prostatic Cancer, Cardiff, Alpha Omega Alpha, p. 151, 1970.
7. Jensen, E.V.; DeSombe, E.R., and Jungleblut, P.W.: Estrogen Receptors in Hormone-Responsive Tissue and Tumors. In Wessler, R.W.; Dao, T.L., and Wood, S. (eds.): Endogenous Fators Influencing Host-Tumor Balance, Chicago, University of Chicago Press, p. 15, 1967.
8. Maass, H.; Engle, B.; Hohmeister, H., et al: Estrogen Receptors in Human Breast Cancer Tissue, Am. J. Obstet. Gyn. 113:337-382, 1972.
9. Engelsman, E.; Persijn, J.P.; Korsten, C.B., et al: Oestrogen Receptors in Human Breast Cancer Tissue and Response to Endocrine Therapy, Brit. Med. J. 2:750-752, 1973.
10. Leung, B.S.; Fletcher, W.S.; Lindell, T.D., et al: Predictability of Response to Endocrine Ablation in Advanced Breast Carcinoma, Arch. Surg. 106:515-519, 1973.
11. Savlov, E.D., Wittliff, J.L.; Hilf, R., et al: Correlation Between Certain Biochemical Properties of Breast Cancer and Response to Therapy: Preliminary Report, Cancer 33:303-309, 1974.
12. Toft, D. and Gorski, J.: Receptor Molecule for Estrogens, Proc. Natl. Acad. Sci. USA 55:1574-1581, 1966.
13. Shyamda, G. and Gorski, J.: Interrelationship of Estrogen Receptors in Nucleus and Cytosol, J. Cell. Biol. 35:125A (Abst.), 1967.
14. Jensen, E.V.; Suzuki, T.; Kawashima, T., et al: Two Step Mechanism for Interaction of Estradiol with Rat Uterus, Proc. Natl. Acad. Sci. USA 59:632-638, 1968.
15. Chamness, G.C.; Mercer, W.D., and McGuire, W.L.: Are Histochemical Methods for Estrogen Receptor Valid? J. Histochem. Cytochem. 28:792-798, 1980.
16. Clark, J.H.; Hardin, J.W.; Upchurch, S., et al: Heterogeneity of Estrogen Binding Sites in Cytosol of Rat Uterus, J. Biol. Chem. 253:7630-7634, 1978.
17. Eriksson, H.; Upchurch, S.; Hardin, J.W., et al: Heterogeneity of Estrogen Receptors in Cytosol and Nuclear Fractions of Rat Uterus, Biochem. Biophys. Res. Commun. 81:1-7, 1978.
18. Markaverich, B.M. and Clark, J.H.: Two Binding Sites for Estradiol in Rat Uterine Nuclei: Relationship to Uterotropic Response, Endocrinology 105:1458-1462, 1979.
19. Hutchins, T.W.; Viehle, R.D.; Shahabi, N.A., et al: Rapid Analysis of Estrogen Receptor Heterogeneity by Chromatofocusing with High Performance Liquid Chromatography, J. Chromatogr. 266:115-128, 1983.
20. Anonymous: Proceeding of NIH Consensus Development Conference on Steroid Receptors in Breast Cancer, Cancer 46:2759-2963, 1980.
21. DeSombre, E.R.; Carbone, P.P.; Jensen, E.V., et al: Steroid Receptors in Breast Cancer, N. Engl. J. Med. 301:1011-1012, 1979.
22. Wittliff, J.L.: Steroid-Hormone Receptors in Breast Cancer, Cancer 53:630-643, 1984.
23. Bland, K.L.; Fuchs, A., and Wittliff, J.L.: Menopausal States as Factor in Distribution of Estrogen and Progestin Receptor in Breast Cancer, Surgical Forum 32:410-412, 1981.
24. Kiang, D.T. and Kennedy, B.J.: Factors Affecting Estrogen Receptors in Breast Cancer, Cancer 40:1571-1576, 1977.
25. Poulsen, H.S.: Oestrogen Receptor Assay-Limitation of Method, Eur. J. Cancer 17:495-501, 1981.
26. Wittliff, J.L.; Beatty, B.W.; Savlov, E.D., et al: Estrogen Receptor and Hormone Dependency. In St. Ameualt, G.; Bond, P.; Israel, L. (eds.): Recent Results in Cancer Research, New York, Springer-Verlag 59-77, 1977.
27. DeSombre, E.R. and Jensen, E.V.: Estrophilin Assays in Breast Cancer: Quantitative Features and Applications to Mastectomy Specimen, Cancer 46:2783-2788, 1980.
28. Henson, J.C.; Longeval, E.; Mattheiem, W.H., et al: Significance of Quantitative Assessment of Estrogen Receptors for Endocrine Therapy in Advanced Breast Cancer, Cancer 39:1971-1977, 1977.
29. Paredacns, R.; Sylvester, R.T.; Ferrazzi, E., et al: Clinical Significance of Quantitative Assessment of Estrogen Receptors in Advanced Breast Cancer, Cancer 46:2889-2895, 1980.
30. Byar, D.P.; Sears, M.E.; McGuire, W.L., et al: Relationship Between Estrogen Receptor Values and Clinical Data in Predicting Response to Endocrine Therapy for Patients with Advanced Breast Cancer, Eru. J. Cancer Clin. Oncol. 15:299-310, 1979.
31. Jensen, E.V.; Block, G.E.; Smith, S., et al: Estrogen Receptors and Breast Cancer Response to Adrenalectomy, Natl. Cancer Inst. Monogr. 34:55-70, 1971.
32. McGuire, W.L.; Carbone, P.P.; Sears, M.E., et al: Estrogen Receptors in Human Breast Cancer: Overview. In McGuire, W.L.; Carbone, P.P., and Vollmer, E.P. (eds.): Estrogen Receptors in Human Breast Cancer, New York, Raven Press, pp. 1-7, 1975.
33. Dandliker, W.B.; Brawn, R.J.; Hsu, M.L., et al: Investigation of Hormone-Receptor Interactions by Means of Fluorescence Labelling. Cancer Res. 38:4212-4224, 1978.
34. Lee, S.H.: Cytochemical Study of Estrogen Receptor in Human Mammary Cancer, Am. J. Clin. Pathol. 70:197-203, 1978.
35. Walker, R.A.; Cove, D.H., and Howell, A.: Histological Detection of Oestrogen Receptor in Human Breast Carcinomas, Lancet 1:171-173, 1980.
36. Panko, W.B.; Matteoli, C.A., and Wheeler, T.M.: Lack of Correlation of Histochemical Method for Estrogen Receptor Analysis with Biochemical Assay Results, Cancer 49:2148-2152, 1982.
37. McCarty, K.S. Jr.; Hiatt, K.B.; Budwit, D.A., et al: Clinical Response to Hormone Therapy Correlated with Estrogen Receptor Analysis. Biochemical v Histochemical Methods, Arch. Pathol. Lab. Med. 108:24-26, 1984.
38. Masood, S. and Johnson, H. Jr.: Value of Imprint Cytology in Cytochemical Detection of Steroid Hormone Receptors in Breast Cancer, Am. J. Clin. Pathol. 87:30-36, 1987.
39. Greene, G.L.; Nolan, C.; Engler, J.P., et al: Monoclonal Antibodies to Human Estrogen Receptor, Proc. Natl. Acad. Sci. USA 77:5115-5119, 1980.
40. Nenci, I.: Receptor and Centriole Pathways of Steroid Action in Normal and Neoplastic Cells, Cancer Res. 38:4204-4211, 1978.
41. Nenci, I.; Biceati, M.D.; ;Piffanelli, A., et al: Detection and Dynamic Localization of Estradiol-Receptor Complexes in Intact Target Cells by Immunofluorescence Technique, J. Steroid Biochem. 7:505-510, 1976.
42. Pertschuk, L.P.: Detection of Estrogen Binding in Human Mammary Carcinoma by Immunofluorescence: New Technique Utilizing Binding Hormone in Polymerized State, Res. Commun. Chem. Pathol. Pharmacol. 14:771-774.
43. Pertschuk, L.P.; Tohin, E.H.; Brigati, D.J., et al: Immunofluorescent Detection of Estrogen Receptors in Breast Cancer: Comparison with Dextran-Coated Charcoal and Sucrose Gradient Assays, Cancer 41:907-911, 1978.
44. Ghosh, L.; Ghosh, B.C., and DasGupta, T.K.: Immunocytochemical Localization of Estrogen in Human Mammary Carcinoma Cells by Horseradish-Antihorseradish Peroxidase Complex, J. Surg. Oncol. 10:221-224, 1978.
45. Kurzon, R.M. and Sternberger, L.A.: Estrogen Receptor Immunocytochemistry, J. Histochem. Cytochem. 26:803-808, 1978.
46. Greene, G.L. and Jensen, E.V.: Monoclonal Antibodies as Probes for Estrogen Receptor Detection and Characterization, J. Steroid Biochem. 16:353-359, 1982.
47. Greene, G.L.; Sobel, N.B.; King, W.J., et al: Immunochemical Studies of Estrogen Receptors, J. Steroid Biochem. 20:51-56, 1984.
48. Poulsen, H.S.; Ozello, L.; King, W.J., et al: Use of Monoclonal Antibodies to Estrogen Receptors (ER) for Immunoperoxidase Detection of ER in Paraffin Sections of Human Breast Cancer Tissue, J. Histochem. Cytochem. 33:87-92, 1985.
49. Shimada, A.; Kumura, S.; Abe, K., et al: Immunocytochemical Staining of Estrogen Receptor in Paraffin Sections of Human Breast Cancer by Use of Monoclonal Antibody: Comparison with that in Frozen Section, Proc. Natl. Acad. Sci. USA 82:4803-4807, 1985.
50. Andersen, J.; Orntoft, T., and Poulsen, H.S.: Semiquantitative Oestrogen Receptor Assay in Formalin-Fixed Paraffin Sections of Human Breast Cancer Tissue Using Monoclonal Antibodies, Br. J. Cancer 53:691-694, 1986.
51. Shintaku, U.P. and Said, J.W.: Detection of Estrogen Receptors with Monoclonal Antibodies in Routinely Processed Formalin Fixed Paraffin Sections of Breast Carcinoma. Use of DNase Pretreatment to Enhance Sensitivity of Reaction, Am. J. Clin. Pathol. 87:161-167, 1987.
52. Flowers, J.L.; Burton, G.V.; Cox, E.B., et al: Use of Monoclonal Antiestrogen Receptor Antibody to Evaluate Estrogen Receptor Content in Fine Needle Aspiration Breast Biopsies, Ann. Surg. 203:250-254, 1986.
53. King, W.J., DeSombre, E.R.; Jensen, E.V., et al. Comparison of Immunocytochemical and Steroid Binding Assays for Estrogen Receptor in Human Breast Tumor, Cancer Res. 45:293-304, 1985.
54. McCarty, K.S. Jr.; Miller, L.S., Cox, E.B., et al: Estrogen Receptor Analyses, Correlation of Biochemical and Immunohistochemical Methods Using Monoclonal Antireceptor Antibodies, Arch. Pathol. Lab. Med. 109:716-721, 1985.
55. McClelland, R.A., Berger, U.; Miler, L.S., et al: Immunocytochemical Assay for Estrogen Receptor in Patients with Breast Cancer: Relationship to Biochemical Assay and to Outcome of Therapy, J. Clin. Oncol. 4:1171-1176, 1986.
56. Jordan, V.C.; Jacobson, H.I., and Keinan, E.J.: Determination of Estrogen Receptor in Breast Cancer Using Monoclonal Antibody Technology: Results of Multicenter Study in United States, Cancer Res. 46:4241s-4243s, 1986.
57. McClelland, R.A.; Berger, U.; Miller, L.S., et al: Immunocytochemical Assay for Estrogen Receptor. Relationship to Outcome of Therapy in Patients with Advanced Breast Cancer, Cancer Res. 46:4241s-4243s, 1986.
58. Magdelerat, H.; Merle, S., and Zajdela, A.: Enzyme Immunoassay of Estrogen Receptors in Fine Needle Aspirates of Breast Tumors, Cancer Res. 46:4265s-4267s, 1986.
59. Goussard, J.; Lechevrel, C.; Martin, P.M., et al: Comparison of Monoclonal Antibodies and Tritiated Ligands for Estrogen Receptor Assays in 241 Breast Cancer Cytosols, Cancer Res. 46:4282s-4287s, 1986.

- Dr. Meredith, Orlando Regional Med. Cnt. Dept. of Pathology, 1414 S. Kuhl Ave., Orlando 32806-2093.

Report on an Outbreak of Lymphogranuloma Venereum in Central Florida

Stan Epling and G.A. Reich, M.D., M.P.H.

***ABSTRACT:* Highlands County experienced an outbreak of lymphogranuloma venereum during the winter of 1986-87. It later occurred in nearby counties. Lymphogranuloma venereum (LGV) is not expected to be encountered very frequently, especially in rural areas. Contact tracing was effective for case-finding and eventual control.**

The Authors
STAN EPLING
G.A. REICH, M.D., M.P.H.
Mr. Epling is the Disease Intervention Specialist for Highlands and Hardee Counties. Dr. Reich is Health Officer for Highlands County.

Lymphogranuloma venereum (LGV) is not a very common disease in central Florida. This is not to say that it does not occur but rather that it is rarely seen by the health department. The last confirmed case in Highlands County was about 20 years ago. In this day of PPNG, AIDS, and the resurgence of primary syphilis, it would be very easy to forget all about it.

During January to March 1987, we confirmed 22 cases of LGV. In reviewing our records for the previous several months, we now see where there may have been more. At first we were collecting specimens for culture and smear for chancroid and granuloma inguinale, all of which were negative. We were not able to get patients back from the previous few months to draw blood for LGV titers.

LGV is said to be more common in sailors, soldiers, travelers and urban areas. However, none of our cases fits into any of these categories.

Cases ● The table depicts the data for these 22 cases. The disease was predominantly in blacks, males, and those in an age range somewhat older than we usually see with gonorrhea, chlamydia, and syphilis.

Seventy-three percent were black, 17% Hispanic, 85% male, and the average age was 30 (range 21-46). Eighty-five percent had ulcers and 37% had inguinal adenopathy. One case also had gonorrhea and another had secondary syphilis. We believe, based upon our epidemiologic investigation, that four prostitutes who follow the migrants were the source of this outbreak because they were named by so many males.

Treatment problems ● The Public Health Service (CDC) guidelines for treatment recommend tetracycline 500 mg qid, for two weeks. However, most of our patients took about three weeks to clear up and a few took longer. This weekly follow-up and patient education is extremely important.

Table 1.—Cases of LGV.

DX DATE	AGE	RACE	SEX	SIGNS: DISCHARGE	SIGNS: ULCER	SIGNS: LYMPHADEN-OPATHY	LGV TITRE
1/14/87	46	B	M		X	X	1:128
2/11/87	32	B	M			X	1:32
2/11/87	37	B	M		X	X	1:32
2/11/87	32	W	M		X		1:128
2/11/87	28	B	M		X		1:32
2/11/87	30	B	M		X		1:64
2/11/87	29	B	F	X			1:256
2/18/87	21	B	M		X		1:64
2/20/87	31	B	F		X	X	1:32
2/20/87	24	B	F		X		1:32
3/9/87	44	B	M		X	X	1:32
3/9/87	36	B	M		X		1:32
3/9/87	43	B	F		X		1:128
3/9/87	21	W	M		X		1:32
3/9/87	21	W	M		X		1:128
3/9/87	24	W	M		X		1:64
3/9/87	29	W	M		X		1:128
3/13/87	27	B	M		X		1:64
3/26/87	24	B	F		X	X	1:32
3/26/87	40	B	M		X		1:64
3/26/87	26	B	M		X	X	1:32
3/27/87	26	W	M		X	X	1:32

Discussion ● The complement fixation test was used for titers. Titers below 1:64 should be viewed with caution; however, in the presence of an obvious outbreak with apparent clinical manifestations where syphilis, chancroid, and granuloma inguinale have been ruled out, the probability is very high. The first few confirmed cases came in because of painful bubos but, with field investigation for contacts, we were able to identify quite a few in the early stages where ulcers were present. Usually patients are not seen until their painful bubos cause them to come in to the clinic.

Beginning a few weeks later, health officials in Polk County (just north of Highlands County) began to see what they thought was chancroid. Laboratory testing, however, revealed that they were dealing with LGV. So far 11 cases have been confirmed; all presenting with painful bubos. Only five had ulcers. LGV titers have ranged from 32 to 256, and the age range is 21 to 68, males 2:1 over females. Several cases have also presented with primary syphilis.

While the outbreak in Highlands County appears to be nearly over, the one in Polk is continuing. We also understand that chancroid has been diagnosed in Manatee County. This is turning out to be LGV, based upon C/F tests.

These reports show us that we have to be on the outlook for even rare venereal diseases. This is a reflection of the change in sexual behavior occurring even in the rural communities. Crack cocaine is clearly a part of our problem. Addicted women turn to sex to generate sufficient income to purchase the drug.

● Dr. Reich, Highlands County Public Health Unit, Courthouse Annex, Sebring 33870.

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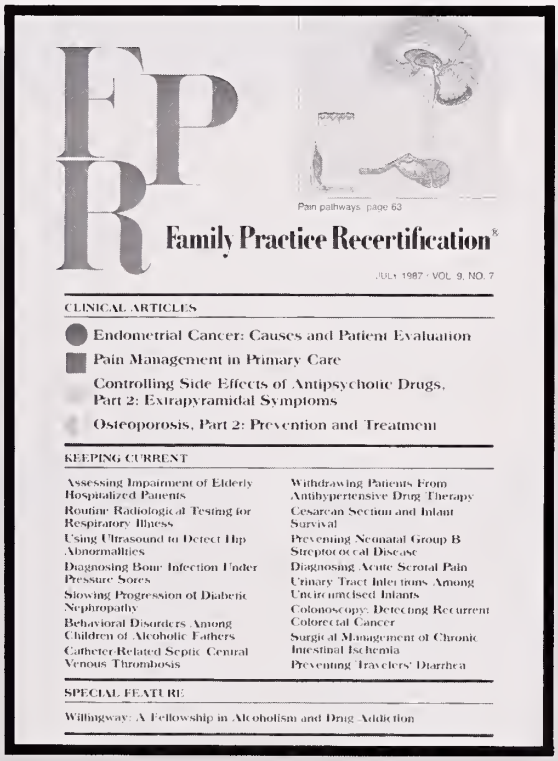
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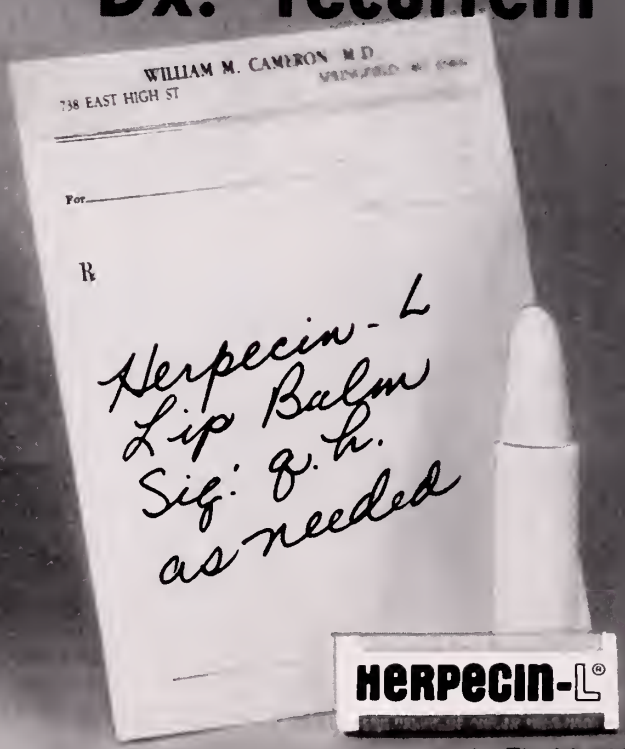

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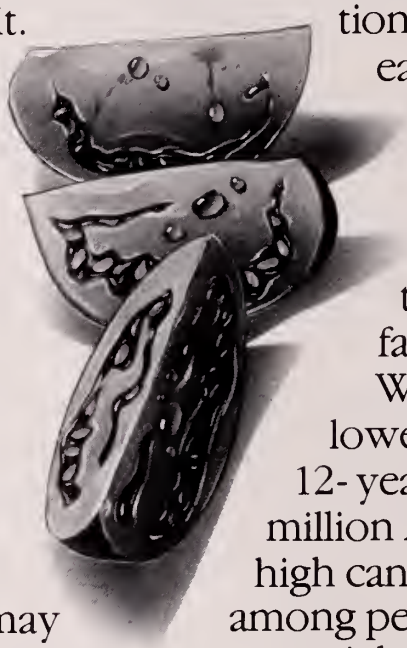

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Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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AMA Interim Meeting: A Myriad of Issues, a Single Voice

R. G. Lacsamana, M.D.

The interim meeting of the AMA held from December 6 to 9 at the Marriott-Marquis in Atlanta offered a good glimpse of what is coming for the American physician in 1988. Four hundred six delegates from 50 states and various medical specialty societies tackled a whole gamut of issues ranging from PAP smears to AIDS, from the nursing shortage to the excessive working hours of resident physicians, and from mandatory Medicare assignment to the care of indigent patients. The diversity of problems and the intense, often heated debates and discussion on how best to approach and solve these problems reflected the mood of uncertainty that has permeated American medicine for the past few years. There was much to be jubilant about, but also a lot to worry about.

The roster of delegates was eclectic and impressive: they represent the best minds of American medicine. The list included several past AMA presidents, current AMA officers and members of the Board of Trustees, delegates and alternate delegates, medical students, resident physicians, young physicians, county medical society executives, and an assortment of observers from everywhere. Every imaginable segment of American medicine was represented.

Florida had a full contingent ably led by Dr. Joseph Von Thron of Cocoa Beach. Joe had a quiet hectic schedule guiding the activities of his delegation, moderating a symposium on AIDS on the first day of the meeting, and hosting a hospitality party for AMA delegates on behalf of the FMA. Also on hand were FMA President Dr. James White; past AMA President Dr. Ed Annis; Dr. Rufus Broadaway of the Board of Trustees; Executive Vice President Don Jones; and a good number of county medical society executives.

The Florida delegates stood out everywhere with their bright orange jackets. At reference committee meetings, they introduced a number of resolutions on the PRO, Medicare, the professional liability problem, and student medical loans. They participated vigorously as well in the discussion and debates on a wide range of issues. One of them, Dr. T. Byron Thames, was a member of the reference committee representing the Board of Trustees.

The bulk of the work at the meeting was carried out at the sessions of the nine reference committees which deliberated on 32 reports from the Board of Trustees, 23 reports from Councils of the Board, and 77 resolutions introduced by various state delegations. Discussion in these meetings was always spirited and intelligent, often punctuated by humor, wit, and sharp exchanges. Although final decisions on the resolutions and reports were made at the House of Delegates, the reference committee meetings afforded delegates their best forum to express their views fully, almost with no constraints. As an observer attending my first AMA meeting, I was quite impressed by the hard work, dedication, and sharp grasp of the issues displayed in these meetings. Some reference committees took almost a day to complete deliberations on the issues, a reflection of the extraordinary amount of business that was transacted during the meeting.

The AMA, in recent years, has tried to encourage broader participation among its younger members, and they responded with gusto. Medical students,

The AMA House of Delegates in session.

Joseph Von Thron, M.D., Brevard County, speaking at the Southeastern caucus.

residents in training, and young physicians in practice articulated well their concerns to their elders. Many subjects were discussed at the session of the students including AIDS education, student loans, and crisis pregnancy clinics. Young physicians, on the other hand, were concerned by two things: (1) the MAAC fee schedules which discriminate against them, and (2) the claims-made malpractice policies which restrict their freedom to move from one place to another. However, it was the resident physicians who upstaged everybody when they brought up the issue of "excessive working hours" during their training. The House of Delegates, after fierce deliberations, approved guidelines that in effect would limit resident working hours and reduce the amount of scut work. The issue, however, is far from resolved. Many physicians expressed concerns about the additional funding and additional physicians needed to implement these changes.

At the first session of the House of Delegates on December 7, two physicians were honored for their contributions to American medicine. Dr. C. Everett Koop, Surgeon General of the United States, received the AMA-ERF award for his unyielding leadership in espousing public health policies particularly in the areas of substance abuse and AIDS education. Dr. Mason Cook Andrews of Norfolk received the Benjamin Rush Bicentennial Award for his civic and professional activities. Dr. William Hotchkiss, president of the AMA, also delivered his presidential address, pointing to physicians' loss of autonomy and increasing third-party intrusion as the two most pressing problems facing physicians today.

The last two sessions of the House of Delegates were spent in voting on the resolutions and reports taken up by the reference committees. The course of American medicine, in a large measure, will be determined by what took place in these sessions.

Here is a brief summary of the more important actions taken by the House of Delegates:

PRO: Although there was substantial opposition to the PROs, the House voted to work for a modification instead of a repeal of the program, reasoning that the HCFA lately had been more receptive to physicians' suggestions and that the government and the public would not be satisfied to continue running an expensive Medicare program without checks and balances.

AIDS: The House, through a report of the Board of Trustees, affirmed the ethical obligations of physicians in treating AIDS patients, urged more public education, and rejected mandatory testing for patients.

PROFESSIONAL LIABILITY: The House endorsed a Florida resolution to search for alternatives to the current tort system and to look at MICA (now MIRA) as a possible model of legislation in other states.

RELATIVE VALUE STUDY: Delegates urged the AMA to monitor the Harvard study closely, develop criteria for evaluating its findings, allow more physician input, and release it for consideration by delegates no later than the June annual AMA meeting.

AMA SPECIALTY JOURNALS: The House voted to go to controlled circulation, meaning that all specialty journals will now be sent free to all physicians within a particular specialty regardless of their AMA affiliation. Physicians who received these journals free before can subscribe to them at 25% discounts. Family physicians objected vigorously to this policy, citing possible defection from the AMA ranks.

MANDATORY ASSIGNMENT: There was unanimous opposition to this. Delegates from the state of Washington focused on the defeat by voters of mandatory assignment in a referendum last November.

FMA delegates hosting a hospitality party.

James C. White, M.D., FMA President, with some Florida boosters; left to right, Mrs. Gloria Barkin, Executive Director, Volusia County Medical Society; Mrs. Molly Hill, Executive Director, Capital Medical Society; Dr. White; Mrs. Peggy Davenport, Executive Director, Alachua County Medical Society; and Mrs. Cynthia Peterson, Executive Director, Indian River County Medical Society.

Alvin E. Smith, M.D., Volusia County, making a point at a reference committee meeting.

Other states have adopted voluntary assignment programs for indigent and Medicare patients.

PAP SMEARS: Delegates adopted a policy urging an annual Pap smear for three consecutive years in women over 18 years of age who are or have been sexually active, with the discretion to do them less often after this period. This would replace the old policy recommended by the American Cancer Society.

NURSING SHORTAGE: The House recommended a five-part program to encourage more people to go into nursing and to ease the recurring nursing shortage. Boosting the pay of nurses was one of the recommendations.

MAAC FEE SCHEDULES: The House voted to seek legislation to eliminate fee distortions and to eliminate classifying physicians as participating and nonparticipating.

FMGs: Delegates adopted a resolution to encourage foreign medical graduates to participate more in organized medicine and to give recognition and nonmonetary awards to those who excel in their activities for their medical societies.

RIGHT TO DIE MEASURES: The House adopted guidelines for DNR orders, among other things, and the AMA will be sending these to medical staffs for use in their own hospitals. The JCAHO now requires hospitals to adopt DNR policies.

FEDERAL RESTRICTIONS ON MEDICAL LICENSURE: The House bitterly opposed such restrictions, citing that these are an unjustified intrusion to state rights.

As the gavel sounded for the final time on December 9, delegates left the meeting with a feeling that a lot was accomplished and also with the knowledge that the problems are not over yet. But above and beyond these problems, the AMA continued to reassert its role as the best single voice to represent all American physicians and the interests of their patients.

Occupational Health in the Wood Pulp and Paper Industry: A Review with Implications for Florida Practitioners

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***ABSTRACT:** The wood pulp and paper industry (SIC Code 26) is Florida's tenth largest manufacturing endeavor. Recent statistics reveal a work force of 15,380 employees and an annual payroll of almost $400 million. At least 61% of the occupations in the industry are exposed to known workplace health hazards. Workers are at risk for a number of types of morbidity and mortality including accidental injury, heat stress, noise-induced hearing impairment, and occupational dermatitis. In addition, a variety of respiratory and neoplastic diseases have been shown to be associated with pulp and paper industry employment. The impact of these risks on the health of workers within the state of Florida is largely unknown. However, even with the present, limited state of knowledge, primary care practitioners can contribute to the reduction of worker morbidity and mortality by providing adequate patient education and medical surveillance.*

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More than 600,000 U.S. workers were employed in the paper and allied products industry (SIC Code 26) in 1984, 15,380 (2.3%) within the state of Florida. Ten Florida counties had wood pulp and paper (P&P) industries employing 500 or more workers; Duval County had the greatest number, 2,925, equal to 0.5% of the Jacksonville metropolitan statistical area population. Pulp, paper, and paper products was Florida's tenth largest manufacturing industry with an annual payroll of almost $400 million.[1,2] The health of a substantial number of Florida inhabitants may be influenced by occupational health risks associated with the P&P industry. This review summarizes the current state of knowledge concerning those risks and suggests measures which can be taken by health care practitioners to decrease the rates of worker morbidity and mortality.

Description of the industry ● Paper is made in essentially three steps. First, wood, rags, or other cellulose-containing materials are converted into an aqueous suspension of fine fibers called "pulp". Second, raw pulp is passed through a series of processing steps which may include bleaching with chlorine or chlorine compounds, washing, refinement of fiber size, and addition of various dyes and fillers. Last, a thin, moving slurry of the resulting mixture is dried by heat, drainage, and convection and is simultaneously pressed between heated cylinders to form paper.[3,4]

Variations of the general process are employed for different starting materials and for manufacturing different types of paper. Several important variations, from an occupational health perspective, concern the method of converting wood to pulp. This may be achieved entirely by repeated grinding steps ("groundwood pulp") or by chemical digestion of roughly ground wood chips. The three common types of

digestion employ sulfate ("kraft process"), sulfite, or soda ash as the major industrial reagents. Each pulping process exposes workers to slightly different occupational risks.[3,4]

Over 71 different occupations are found in the P&P industry. Workers may be supervisory, operators of boilers, furnaces, or machinery, or involved in sampling and testing the product. Each occupation has its own set of physical demands and exposures to physical, chemical, or biological hazards. The most important of these are summarized in Table 1; details regarding individual occupations can be found in U.S. Department of Labor (USDOL) publications.[5,6]

Work related morbidity and mortality ● The known categories of health risk in the P&P industry are outlined in Table 2. For some diseases, an association with P&P industry employment has been demonstrated but the issue of causality has not yet been resolved. Where possible, the most recent epidemiological studies are summarized.

Almost one fourth of P&P industry occupations involve exposure to a "definite risk of bodily injury."[3-7] In 1983, Florida insurance companies compensated 396 cases of disabling injury, i.e., those injuries requiring seven or more lost workdays, in the P&P industry. Among these were 90 particularly serious injuries including fractures, crushing injuries, and loss-of-use injuries from amputation or paralysis. Figure 1 depicts the Florida occupational injury rate for that year.[2,8] As is evident, the P&P industry had an injury rate over 200% higher than the remainder of the Florida work force and over 20% higher than the average for all other manufacturing industries ($p<0.001$). Further, the data reported is almost assuredly an underestimate: many worker injuries are not reported or are not defined as disabling because fewer than seven workdays are lost.[8-10] The total injury rate for the P&P industry nationwide approaches 10 per 100 employees per year.[1]

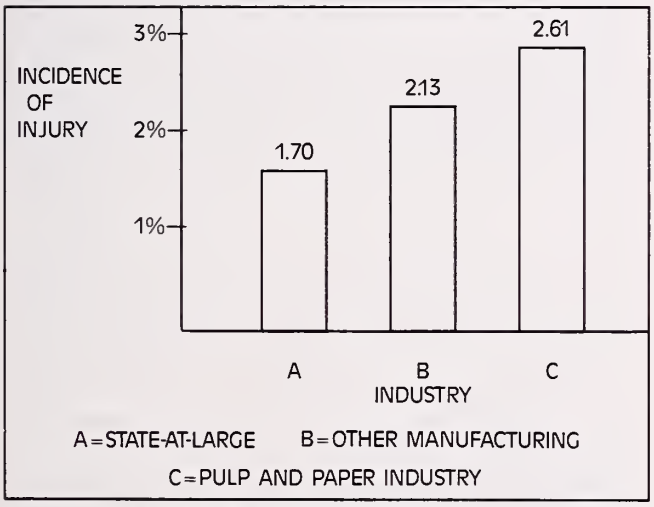

FIG. 1.—Incidence of Disabling Injury by Industry, Florida, 1983. Injury rates are expressed as percentages, i.e., numbers of injuries per 100 employees per year (for additional detail, see text).[2,8]

Table 1.—Physical Demands and Hazardous Exposures of Pulp and Paper Industry Occupations.

PHYSICAL DEMANDS	NUMBER (%) OF OCCUPATIONS*
Manual Manipulations	66 (93.0)
Discriminative Vision	39 (54.9)
Lifting:	
Up to 50 lbs.	25 (35.2)
Up to 100 lbs.	7 (9.9)
Climbing and Balancing	18 (25.4)
Stooping, Kneeling, Crouching, Crawling	18 (25.4)
Hearing and Speech Communication	16 (22.5)
HAZARDOUS EXPOSURES	
Noise and Vibration	29 (40.8)
Wetness and Humidity	18 (25.4)
Risk of Injury	16 (22.5)
Inadequate Ventilation, Fumes, Dusts and Toxins (including contact toxins)	11 (15.5)
Manual Chemical Handling	8 (11.3)
Extreme Heat	6 (8.5)

* Of a total of 71 occupations

References: 5,6

Table 2.—Categories of Occupational Health Risk in the Pulp and Paper Industry.

Traumatic Injury
Thermal Injury and Heat Stress
Noise-Induced Hearing Loss
Occupational Dermatitis
Nonneoplastic Respiratory Disease
Neoplasia

Excessive heat is an almost ubiquitous hazard in the production areas of P&P mills. Boiling, washing, sulfate recovery, and drying processes all create a hot, humid working environment.[3,4] Heat-stress reactions are a common result, sometimes requiring preventive measures such as air-conditioned operator enclosures and water-electrolyte replacement programs.[4,7] The prevailing temperature and humidity may also contribute to the incidence of respiratory disease and obvious risk of burns and scalding. USDOL sources list only six occupational titles considered to be at risk, but this may be overly conservative.[6] Further, it is possible that the higher ambient temperatures of the Florida climate indirectly accentuate the risks.[11] Unfortunately, very little numerical data relative to any of these effects are available.

There is substantial risk of noise-induced hearing impairment for workers throughout the P&P industry. Ambient noise levels in mills have been documented at 80-105 decibels (dBA) and possibly higher.[3,4] The National Institute for Occupational Safety and Health (NIOSH) has shown convincing evidence for a 25% prevalence of material hearing impairment at age 55 due to a working lifetime of exposure to 90 dBA as an 8-hour time-weighted average.[12] Accordingly, Occupational Safety and Health Administration (OSHA) regulations require a mandatory hearing conservation program at 85 dBA or higher noise levels.[13] Up to 41% of the job classifications in the P&P industry may be exposed to such levels of workplace noise.[6] However, NIOSH has more recently shown risks of impairment even in the 80-85 dBA range.[12] The Florida Bureau of Industrial Safety and Health (Department of Labor and Employment Security, Division of Worker's Compensation) advises the use of protective earmuffs or earplugs by all persons in P&P mill production areas.[7] This practice could further reduce the lifetime prevalence of impairment by 20%.[12]

Occupational dermatitis is the most frequently reported, nontraumatic, work-related illness. National statistics for all industries show an incidence of 15.2 cases per 10,000 employees per year.[14] At least three authors have reported cases of this disease in the P&P industry, but information on the relative risk is generally lacking.[14-16] In one study, conducted in South Carolina, there was an incidence of 9.9 cases per 10,000 P&P industry employees. This was not significantly different from the statewide average for all industries.[14]

A large number of known dermatitogenic agents are found in P&P mills. Their presence and use varies widely between mills and between processes within a mill.[4] Some of the major recognized agents are listed in Table 4.[3,4,15,17-26] The most common types are slimicides, antimicrobial agents added to the pulp slurries of mills manufacturing high-quality, bleached paper.[4,15,25] Exposure to slimicides may occur via leakage or splashing of the slurry and can result in either allergic or irritative contact dermatitis or even more severe reactions. Other agents listed in the table include bleaches, caustics, wood dusts, and fungal contaminants, all of which cause similar types of reactions to those resulting from slimicide exposure.[20-24,26] Additional toxicological information and case reports can be found by consulting the references given.

There is a long recognized association between employment in P&P mills and certain nonneoplastic respiratory diseases.[23,27,28] A high incidence of nonspecific symptoms such as wheezing, cough, and sputum production and a variety of pathological conditions has been reported.[3,24,29,30] In fact, due to the broad range of clinical syndromes and etiological agents reported, interpretation of the literature is quite difficult. One possible organizing rubric is shown in Table 5, which lists the major known or presumptive etiological agents found within the industry and the conditions with which they are associated.[20,23,24,27-39]

Exposure to the noxious gases listed in the first half of the table occurs primarily in bleaching and washing operations and in the digestion process of chemical P&P mills.[3,4,7] Kraft mills especially generate large amounts of sulfur dioxide and mercaptans.[3,4] Acute, high-level exposure to any of these gases will cause a generally similar sequence of effects. These have been well-described elsewhere but, to summarize, are characterized by progressive,

Table 3.—Risk Factors and Subject Operations for Traumatic Injury in the Pulp and Paper Industry.

RISK FACTORS

- Dangerous Machinery
  - Debarkers
  - Chippers
  - Pulp Grinders
  - Steam/Power Driven Rollers
- Wet, Slippery Environment
- Heavy Loads
- Catwalks, Ladders, Scaffolding, Staircases

SUBJECT OPERATIONS

- Wood Room
- Pulping
- Washing
- Wet-End
- Dry-End

References: 3-7

Table 4.—Dermatitogenic Agents in the Pulp and Paper Industry.

CLASS AND AGENT	REFERENCE
Slimicides	
Sodium Pentachlorophenolates	17
Bis-1, 4-bromoacetoxy-2-butene	15
Ethylenediamine (solvent)	18,25
Others	25
Bleaches	
Sodium Hypochlorite (NaClO)	21,22
Caustics	
Soda Ash (Na_2CO_3)	26
Caustic Soda (NaOH)	26
Wood Dusts	20,23,24
Fungi	24
Miscellaneous	
Formaldehyde	19,25
Turpentine	3,4,20

Table 5.—Agents of Respiratory Disease in the Pulp and Paper Industry.

CLASS AND AGENT	CLASS—ASSOCIATED CONDITIONS
Noxious Gases	
Chlorine (Cl_2)	Muscosal Irritation
Chlorine Dioxide (ClO_2)	Respiratory Distress
Sulfur Dioxide (SO_2)	Pneumonia
Hydrogen Sulfide (H_2S)	Respiratory Arrest
Methyl Mercaptan (CH_3SH)	Chronic Airway Obstruction*
Organic Dusts and Aerosols	
Wood Dusts	Occupational Asthma
Fungal Spores	Hypersensitivity Pneumonitis
	Chronic Airway Obstruction*

* Association with P&P industry employment has been demonstrated but the issue of causality is still a subject of considerable debate. See text for further details.

References: 20,23,24,27-39

Table 6.—Neoplasms Associated with Pulp and Paper Industry Employment.

DISEASE OR SITE	RISK ESTIMATIONS*	REFERENCE
Hodgkin's Disease	1.92**	46
	1.4	50
	Increased†	45
Stomach	2.8**	49
	2**	48
	1.76**	47
Small Intestine	4.47**	46
	4.44**	47
Multiple Myeloma	2.43**	46
	2	48
Pancreas	2**	48
Malignant Melanoma	2**	48
Buccal Cavity and Pharynx	Increased**	48

*Only tumors for which significantly elevated risks have been shown are included. To facilitate comparison, all numerical risk estimations are expressed as ratios relative to the control group of the study indicated.

** = $p<0.05$ † = $p<0.001$

dose-response related manifestations of respiratory irritation culminating in coma or death.[20,31,32,35,36] Such exposures are less frequent since the inception of OSHA permissible exposure limits (PEL) but still occur on occasion. This is usually due to poor preventive maintenance, technical difficulty, or inadequate ventilation.[7,20]

More recently, attention has been focused on the effects of chronic exposure to low levels of these gases, typically below the PEL. The dominating viewpoint at present is that such exposures can lead to syndromes of chronic airway obstruction with a primarily bronchitic presentation.[30,32,36,39-41] To be strictly accurate, this is still a subject of considerable debate and at least four authors have found no evidence of respiratory impairment due to such exposures in the P&P industry.[33,34] Others, however, have noted such changes as significant increases in the prevalence of bronchitic symptoms and chest-related absenteeism and statistically excessive decreases in pulmonary function tests.[30,42] The latter have occasionally occurred at levels of exposure well below the current PEL.[30] While dose-response relationships have not yet been convincingly demonstrated, laboratory evidence and studies on workers in other industries have tended to support the existence of a casual relationship.[30,35,37,39,41] In view of this body of research, NIOSH recommended exposure limits (REL) for chlorine and sulfur dioxide were recently lowered.[32,36]

Similarly, the wood dusts encountered in the debarking, chipping, and grinding areas of P&P mills may also lead to chronic airway disease. Risks of obstructive changes have been found in a number of wood-based industries in association with chronic wood dust exposure.[20,23,33,38,43] These changes are apparently not allergic reactions and a wide variety of species including both hardwoods and softwoods has been implicated.[23,38,43] Responding to these findings, the American Conference of Governmental Industrial Hygienists recently lowered the threshold limit values for wood dust exposure.[23,44] Data is not yet available on typical exposures within the P&P industry so the degree of risk cannot be presently ascertained.

Finally, a number of the wood dusts and fungal spores found in P&P mills can cause immunologically-mediated disease. These classically-known reactions include both immediate- or delayed-onset asthma and hypersensitivity pneumonitis (extrinsic allergic alveolitis).[23,24,27-29] It has recently become apparent that the etiological agents are not as limited as once thought, but include species found in virtually all P&P mills.[4,20,24,27]

Increased risks for several types of neoplastic disease have been found in association with P&P industry employment. The industry mortality rates due to Hodgkin's disease, multiple myeloma, and cancer of the stomach and small intestine have all been significantly higher than controls in repeated studies.[45-50] In addition, there are other cancer risks that have been shown in at least one report. Table 6 summarizes the findings of a number of case-control studies performed over the last two decades.[45-50]

There are several noteworthy details to be found in these reports. First, workers in other wood-based industries generally were not at increased risk for the particular cancers listed, although there were a few exceptions.[46] Second, there were differences in the risk incurred by workers in mills employing different pulping processes.[47] Pancreatic and gastric cancers were most closely associated with sulfite mills while Hodgkin's disease was associated with kraft mills.[47,49] Third, certain of the risks estimations were remarkably consistent in separate studies.[46,47] Last, some of the findings have been confirmed by different researchers in widely differing populations, specifically those for Hodgkin's disease, gastric cancer, and pancreatic cancer.[48-50]

Admittedly, epidemiological studies do not demonstrate causality, but the replicability of certain of these findings and the magnitude of some of the risk estimations do argue for an occupational etiology. Further, the differences in risk observed between mill types may constitute evidence of the specificity of those risks. If these assertions are in fact true, then the major lacking piece of evidence is the demonstration of a dose-response relationship to exposure.[43] However, no presumptive etiological agent for these neoplasms has been agreed upon, although several have been proposed (Table 7).[45-47,51-54] Therefore, an occupational etiology must be considered only a possibility at present.

There is one additional area of controversy particularly apropos to this review: it concerns the possibility of an occupational risk for pulmonary carcinoma in the P&P industry. For the years 1970-1975, Duval County, Florida, had the highest age-adjusted lung cancer mortality rate in the U.S. (93.2 per 100,000 population).[55] A northeast Florida investigation of the problem revealed no evidence of a lung cancer mortality risk associated with P&P industry employment.[55] However, an earlier, nationwide study by the same author revealed indirect, but statistically significant evidence of such an association.[56] Further, studies in both California and Georgia have documented significantly increased rates of lung cancer mortality among P&P mill workers.[57,58] Because of methodological and extraneous confounds between these various studies, there are no easily drawn conclusions: pulmonary carcinoma in Duval County may or may not be a P&P industry-associated disease.

Significance of reported studies and statistics ● Assessing the impact of the health risks previously reviewed on workers in the Florida P&P industry is a largely uncompleted task. Several factors have impeded signficant progress. In the major statistical report published by the Florida Department of Labor and Employment Security, all noninjury worker's compensation cases are classified under the blanket title "occupational disease."[8] Thus, it is impossible, without direct study, to determine the incidence of specific work-related diseases. Second, occupational illness in general is under-reported.[9] Studies of hospital medical charts have shown that fewer than 10% include an occupational history and national statistics suggest that only one third of work-related disease may be recognized as such.[9,59] Finally, because of frequently changing legislation and increasingly stringent enforcement, the incidence of various work-related diseases are often not stable enough to permit reliable measurement or study.

Table 7.—Proposed Etiological Agents of Cancer in the Pulp and Paper Industry.

Mercaptans
Formaldehyde
Chlorophenols
Intrinsic Wood Dust Components
Wood Breakdown Byproducts
Digestor Reagents and Other Process Chemicals
Preservatives

References: 45-47, 51-54

Nevertheless, there has been some suggestion that morbidity rates are declining.[7] Between 1982 and 1983, there was a 3.6% decrease in disabling injuries for all Florida employees and a 9.4% decrease in the manufacturing industries ($p<0.001$).[8] While this may be only a one year phenomenon, it is consistent with a recent, steady decline on the national level which began in 1979.[1] In addition, the Florida Right-To-Know Law (effective January 1985) should have additional positive impact although data is not yet available.[7] For many of the diseases discussed previously, it is likely that the maximum benefit would not be apparent for five to ten years or more.

Lacking other data, insurance industry assessments can be used as a gross estimate of occupational health risks, given the reservation that substantial bias against nontraumatic forms of morbidity may be present. According to ratings used by the Florida Bureau of Industrial Safety and Health, the P&P industry carries only moderate overall liability. However, the worker's compensation subscore, an index of occupational hazards, is eight out of ten possible points, indicative of high worker risk.[7] Premium rates vary with the type of mill: those for chemical process mills are similar to rates found in light manufacturing industries while those for groundwood mills are approximately 200% higher.[60]

In summary, it is apparent that the general impact of the P&P industry on worker health in the state of Florida is largely unknown. For most of the diseases mentioned in this review, the incidence, relative risk, and etiology, if any, are also unknown. Given the

high personal and societal costs of these diseases, especially respiratory disease and the various neoplasias, further research effort is certainly warranted.

Physician role in risk reduction ● In spite of uncertainties, there are almost always actions which can be taken to reduce risks of work-related morbidity; this is as true for the P&P industry as for any other. Individuals from many different professions, including public officials, plant managers, and experts within the various occupational health specialties can all make important contributions. Two roles are primarily, though not exclusively, within the purview of health care practitioners: medical surveillance and patient education. While larger P&P mills may employ occupational health nurses or physicians for such purposes, many do not.[61] For this reason, the responsibility quite frequently falls to the individual worker's primary care physician.

A complete history and physical examination is central to the fulfillment of surveillance and educational objectives. Examinations should be performed prior to the start of any employment and repeated at one to five year intervals thereafter. Such a practice provides baseline values, aids in the detection of trends towards morbidity, and furnishes important documentation in the event of disability. The first interview with any given patient should include a detailed job description and occupational history in order to evaluate hazardous exposures. Personal and familial risk factors, such as a history of atopy, should also be assessed. Later visits require a thorough Review of Systems in order to detect subtle symptoms of pathophysiology. It is important to remember that many of the conditions associated with the P&P industry will be relatively "silent" until well into their natural course.

Effective medical surveillance in the P&P industry also necessitates certain special examinations. OSHA regulations require yearly audiometry for workers exposed to excessive noise.[10] In view of the NIOSH REL and other data reviewed above, it is reasonable to test all production area personnel.[7,12] Serial spirometry is the surveillance procedure of choice for exposure to many respiratory irritants, including chlorine, sulfur dioxide, and wood dusts.[62] Workers in the wood room, digest, bleaching, washing, or wet-end areas should be tested every one to three years.[62,63]

Finally, workers frequently need education with respect to the health risks and preventive measures associated with their occupations. Worker compliance with industrial hygiene and safety practices is often inadequate but may be improved with frequent reinforcement.[4,10,13,64-66] Primary care physicians can function as a welcome adjunct to management-initiated programs in this regard. A number of areas in which worker understanding or performance may be poor are listed in Table 8.[3,10,11,13,62,64,66-68] In addition, it is possible that workers preinformed about their occupational health risks and the appropriate symptoms could recognize impending disease and seek medical attention earlier, thereby leading to reduced morbidity and mortality.

Table 8.—Industrial Hygiene Topics for Pulp and Paper Industry Employee Education.

ACCIDENT PREVENTION
Body Mechanics
Fatigue
Avoiding Back Strain
HEAT STRESS
Signs and Symptoms
Resting in Cool Location
Water-Electrolyte Replacement
PROTECTION FROM HARM
Shoes and Working Apparel
Hearing Protective Devices
Dust/Mist Barrier Masks
Chemical Respirators
HYGIENE
Hand Washing Before Meals and Coffee Breaks
End of Workday Showering
TOXIC EXPOSURES
"Right-To-Know" Laws
Material Safety Data Sheets (MSDS)
Synergism with Tobacco Use

References: 3,10,11,13,62,64,66-68

It has been said that the major difference between sporadic disease and its occupational counterparts is that the latter are preventable. The measures described, combined with the efforts of professionals in other fields, can decrease the morbidity and mortality experienced by workers in the P&P industry. Such an approach, even with the present, limited state of knowledge, could result in significant financial savings, increased productivity, an atmosphere of management-worker cooperativity, and improved health.

References

1. U.S. Bureau of the Census, Statistical Abstract of the United States, 1986, 106th ed., Washington 1985.
2. Shoemeyer, A.H. (ed.): 1985 Florida Statistical Abstract, 19th ed., University of Florida, 1985.
3. Ross, C.R.: Paper and Pulp Industry, In: Encyclopedia of Occupational Health and Safety, 3rd ed., Parmeggiani, L. (ed.) International Labor Organization, 1983.
4. Personal communication. L.D. Riley, Southwest Forest Industries, Inc., Panama City, Florida, 1986.
5. U.S. Dept. of Labor, Dictionary of Occupational Titles, 4th ed. U.S. Employment Service Publication, Washington 1977.
6. U.S. Dept. of Labor, Selected Characteristics of Occupations Defined in Dictionary of Occupational Titles, U.S. Employment Service Publication, Washington 1981.
7. Personal communication, L. Miles, Florida State Dept. of Labor and Employment Security, Bureau of Industrial Safety and Health, Tampa, Florida, 1986.
8. State of Florida, Worker's Compensation: Statistical Report 1983-84, Florida State Dept. of Labor and Employment Security, 1984.
9. Levy, B.S.: Occupational Health in United States: Its Relevance to Health Professional, In: Occupational Health: Recognizing and Preventing Work-related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown & Co., Boston 1983.
10. DeReamer, R.: Modern Safety and Health Technology, John Wiley & Sons, New York 1980.
11. Hu, H.: Other Physical Hazards and Their Effects, In: Occupational Health: Recognizing and Preventing Work-related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown & Co., Boston 1983.
12. CDC: Leading Work-related Diseases and Injuries — United States: Noise-induced Loss of Hearing, MMWR 35(12):185-188, 1986.
13. Jaffee, B.F.; Bell, D.W., and Irwin, K.: Workplace Noise and Hearing Impairment, In: Occupational Health: Recognizing and Preventing Work-related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown, & Co., Boston 1983.
14. Keil, J.E. and Shmunes, E.: Epidemiology of Work-Related Skin Disease in South Carolina, Arch. Dermatol. 119:650-654, 1983.
15. Rycroft, R.J.G. and Calnan, C.D.: Dermatitis from Slimicides in Paper Mill, Contact Dermatitis 6:77-78, 1980.
16. Efskind, J.: Prevalence of Occupational Eczema in Woodpulp Factory, Contact Dermatitis 6:435-439, 1980.
17. Deichmann, W.B. and Keplinger, M.L.:Phenols and Phenolic Compounds, In: Patty's Industrial Hygiene and Toxicology, 3rd ed., Clayton, G.D. and Clayton, F.E. (eds.), John Wiley & Sons, New York 1981.
18. Beard, R.R. and Noe, J.T.: Aliphatic and Alicyclic Amines, In: Patty's Industrial Hygiene and Toxicology, 3rd ed., Clayton, G.D. and Clayton, F.E. (eds.), John Wiley & Sons, New York 1981.
19. Brabec, M.J.: Aldehydes and Acetals, In: Patty's Industrial Hygiene and Toxicology, 3rd ed., Clayton, G.D. and Clayton, F.E. (eds.), John Wiley & Sons, New York 1981.
20. Finkel, A.J.: Hamilton and Hardy's Industrial Toxicology, 4th ed., John Wright-PSG, Inc., Boston 1983.
21. Eun, H.C.; Lee, A.Y. and Lee, Y.S.: Sodium Hypochlorite Dermatitis (short communication), Contact Dermatitis 11:45, 1984.
22. Osmundsen, P.E.: Contact Dermatitis Due to Sodium Hypochlorite, Contact Dermatitis 4:177-178, 1978.
23. Whitehead, L.W.: Health Effects of Wood Dust-Relevance for Occupational Standard, Am. Ind. Hyg. Assoc. J. 43:674-678, 1982.
24. Cohn, K.K.; Marcero, D.H., and Wojinski, S.F.: Use of GC/MS Analysis and Fungal Culturing in Pulp Mill Industrial Hygiene Program, Am. Ind. Hyg. Assoc. J. 45:594-597, 1984.
25. Fregert, S.: Registration of Chemicals in Industries: Slimicides in Paper-Pulp Industry (short communication), Contact Dermatitis 2:358-360, 1976.
26. Wands, R.C.: Alkaline Materials, In: Patty's Industrial Hygiene and Toxicology, 3rd ed., Clayton G.D. and Clayton, F.E., (eds.), John Wiley & Sons, New York 1981.
27. Schlueter, D.P.; Fink, J.N., and Hensley, G.T.: Wood-pulp Worker's Disease: Hypersensitivity Pneumonitis Caused by Alternaria, Ann. Int. Med. 77:907-914, 1972.
28. Sosman, A.J.; Schlueter, D.P.; Fink, J.N., and Barboriak, J.J.: Hypersensitivity to Wood Dust, N. Engl. J. Med. 281:977-980, 1969.
29. Niemela, S.I.; Vaatanen, P.; Mentu, J.; Jokinen, A.; Jappinen, P., and Sillanpaa, P.: Microbial Incidence in Upper Respiratory Tracts of Workers in Paper Industry, Appl. Environ. Microbiol. Jul. 50(1):163-168, 1985.
30. Enarson, D.A.; Maclean, L.; Dybuncio, A., et. al: Respiratory Health at Pulpmill in British Columbia, Arch. Environ. Health 39:325-330, 1984.
31. Sandmeyer, E.E.: Organic Sulfur Compounds, In: Patty's Industrial Hygiene and Toxicology, 3rd ed., Clayton, G.D. and Clayton, F.E. (eds.), John Wiley & Sons, New York 1981.
32. Mackison, F.W.; Stricoff, R.S., and Partridge, L.J. Jr., (eds.): NIOSH/OSHA Occupational Health Guidelines for Chemical Hazards, U.S. Dept. of Labor, 1981.
33. Chan-Yeung, M.; Wong, R.; Maclean, L., et al: Respiratory Survey of Workers in Pulp and Paper Mill in Powell River, British Columbia, Am. Rev. Respir. Dis. 122:249-257, 1980.
34. Poukkula, A.; Huhti, E., and Makarainen, M.: Chronic Respiratory Disease Among Workers in Pulp Mill: Ten-year Follow-up Study, Chest 81:285-289, 1982.
35. Stokinger, H.E.: Halogens and Nonmetals Boron and Silicon, In: Patty's Industrial Hygiene and Toxicology, 3rd ed., Clayton, G.D. and Clayton, F.E. (eds.), John Wiley & Sons, New York 1981.
36. CDC: NIOSH Recommendations for Occupational Safety and Health Standards, MMWR 34(1S):3S-31S, 1985.
37. Andersen, I.; Lundquist, G.R.; Jensen, P.L., and Proctor, D.F.: Human Response to Controlled Levels of Sulfur Dioxide, Arch. Environ. Health 28:31-39, 1974.
38. Whitehead, L.W.; Ashikaga, T., and Vacek, P.: Pulmonary Function Status of Workers Exposed to Hardwood or Pine Dust, Am. Ind. Hyg. Assoc. J. 42:178-186, 1981.
39. Smith, T.J.; Peters, J.M., Reading, J.C., and Castle, C.H.: Pulmonary Impairment from Chronic Exposure to Sulfur Dioxide in Smelter, Am. Rev. Respir. Dis. 116:31-39, 1977.
40. Huhti, E.; Ryhanen, P.; Vuopala, U., and Takkunen, J.: Chronic Respiratory Disease Among Pulpmill Workers in Artic Area in Northern Finland, Acta Med. Scand. 187:433-444, 1970.
41. Rom, W.N. and Barkman, H. Respiratory Irritants, In: Environmental and Occupational Medicine, Rom, W.N.; Renzetti, A.D.; Lee, J.S., and Archer, V.E. (eds.), Little, Brown & Co. Boston 1983.
42. Skalpe, I.O.: Long-term Effects of Sulfur Dioxide Exposure in Pulp Mills, Br. J. Ind. Med. 21:69-73, 1964.
43. Becklake, M.R.: Chronic Airflow Limitation: Its Relationship to Work in Dusty Occupations, Chest 88(4):608-617, 1985.
44. Personal communication, M. Farmer, OSHA, U.S. Dept. of Lahor, Tampa, Florida, 1986.
45. Milham, S. Jr. and Hesser, J.E.: Hodgkin's Disease in Woodworkers, Lancet 2:136-137, 1967.
46. Milham, S. Jr.: Neoplasia in Wood Pulp Industry, Ann. N.Y. Acad. Sci. 271:294-300, 1976.
47. Milham, S. Jr. and Demers, R.Y.: Mortality Among Pulp and Paper Workers (brief communication), JOM 26:844-846, 1984.
48. Bross, I.D.J.; Viadana, E., and Houten, L.: Occupational Cancer in Men Exposed to Dust and Other Environmental Hazards, Arch. Environ. Health 33:300-307, 1978.
49. Wingren, G.; Kling, H., and Axelson, O.: Gastric Cancer Among Paper Workers (letter), JOM, Oct. 27(10):715, 1985.
50. Greene, M.H.; Brinton, L.A.; Fraumeni, J.F., and D'Amico, R.: Familial and Sporadic Hodgkin's Disease Associated with Occupational Wood Exposure, Lancet 2:626-627, 1978.
51. CDC: NIOSH Current Intelligence Bulletins: Summaries July 1985, MMWR 34(2S):i-51S, 1985.
52. Petersen, G. and Milham, S. Jr.: Hodgkin's Disease Mortality and Occupational Exposure to Wood, J. Nat. Cancer Inst. 53:957-958, 1974.
53. Wills, J.H.: Nasal Carcinoma in Woodworkers: Review, JOM 24(7):526-530, 1982.
54. Voss, R.; Stenerson, T.; Oppedal, B.R., and Boysen, M.: Sinonasal Cancer and Exposure to Softwood, Acta Otolaryngol. 99:172-178, 1985.
55. Blot, W.J.; Davies, J.E.; Brown, L.M., et al: Occupation and High Risk of Lung Cancer in Northeast Florida, Cancer 50:364-371, 1982.
56. Blot, W.J. and Fraumeni, J.F. Jr.: Geographic Patterns of Lung Cancer: Industrial Correlations, Am. J. Epidemiol. 103:539-550, 1976.
57. Menck, H.R. and Henderson, B.E.: Occupational Differenees in Rates of Lung Cancer, JOM 18:797-801, 1976.
58. Harrington, J.M.; Blot, W.J.; Hoover, R.N., et al: Lung Cancer in Coastal Georgia: Death Certificate Analysis of Occupation, J. Nat. Cancer Inst. 60:295-298, 1978.
59. Personal communication, R.T. Myint, M.D., Tampa, Florida, 1987.
60. Personal communication, D. May, State Farm Insurance Co., Tampa, Florida, 1986.
61. Storm, A.H.: Occupational Health and Safety Programs in Workplace, In: Occupational Health: Recognizing and Preventing Work-Related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown & Co., Boston 1983.
62. Wegman, D.H.: Respiratory Disorders, In: Occupational Health: Recognizing and Preventing Work-Related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown, & Co., Boston 1983.
63. NIOSH. Manual of Spirometry in Occupational Medicine, U.S. Dept. of Health and Human Services, USPHS, CDC, NIOSH, 1981.
64. Smith, T.J.; Industrial Hygiene, In: Occupational Health: Recognizing and Preventing Work-related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown, & Co., Boston 1983.
65. Lee, J.S.: Industrial Hygiene: Measurement and Control, In: Environmental and Occupational Medicine, Rom, W.W.; Renzetti, A.D.; Lee, J.S., Archer, V.E. (eds.), Little, Brown & Co., Boston 1983.
66. Levy, B.S. and Wegman, D.H.: Preventing Occupational Disease, In: Occupational Health: Recognizing and Preventing Work-related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown, & Co., Boston 1983.
67. State of Florida, Florida Right-to-Know Law, Chapter 42, Florida Statutes.
68. Arndt, K.A.; Skin Disorders, In: Occupational Health: Recognizing and Preventing Work-related Disease, Levy, B.S. and Wegman, D.H. (eds.), Little, Brown, & Co., Boston, 1983.

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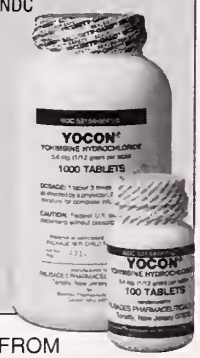

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Physician Participation in the Florida Medicaid System: A Reassessment

Organized medicine continues its struggle to maintain physician primacy over American medical care. If we are to sustain our traditional rights of leadership we must become more responsive to the social needs of the communities in which we practice. Medical indigency is one major social and medical problem that urgently requires physician leadership and commitment. Our inventiveness and participation in resolving and ameliorating this pervasive situation can potentially restore much of the faded political luster of the physician in today's society.

One of Dr. James B. Perry's most successful campaigns during his tenure last year as President of the Florida Medical Association was to prick the Legislature's consciousness about indigent health care. The Legislature responded by sandblasting away a major portion of the tarnish of economically unreasonable fee schedules and ludicrously rigid financial requirements that have characterized the Medicaid program. The resultant indigent care package is neither complete nor ideal in its present form, but it represents a major change in legislative attitude towards its responsibility to the medical care of the poor. Many Florida physicians have not been willing to participate in Medicaid in the past because of its inherent financial unreasonableness. The structural changes mandated by the 1987 Legislature should particularly encourage obstetricians, pediatricians and primary health care doctors to fully participate in the revised Medicaid program. This article will review the Medicaid reforms that were enacted last year and placed into service on October 1.

Florida Medicaid system ● All state-sponsored indigent care is managed by the Department of Health and Rehabilitative Services (HRS) through a mosaic of different projects. Medicaid is only one of the programs that the Department regulates and operates. The 1988 Medicaid budget is projected at $557.4 million; $418.9 million will be spent on inpatient hospital care, $52.3 million on outpatient hospital care, and $86.2 on physician services. Physician reimbursement has been increased $34 million from 1987 — a 65% increase. The majority of these increased funds are targeted toward primary, pediatric and obstetrical care in the form of increased fees.

The federal government contributes 56% of every dollar of Medicaid benefit. This reliance on federal contribution has imposed a heavy burden of administrative regulation and has prevented the introduction of certain clerical efficiencies which would benefit the doctor and other providers.

E.D.S. is the fiscal agent that processes all Medicaid claims. Thirty million claims for prescriptions, M.D. services, hospitalization, nursing home care, etc., were submitted, edited, key-punched, and either paid or denied last year. E.D.S. handles all initial correspondence with providers and works within 11 HRS districts throughout the state (Table 1). The E.D.S. personnel work alongside the HRS staff. E.D.S. activities are continually audited by state and federal people for compliance with Medicaid guidelines. It is paid on a flat fee per claim; no additional funds accrue to it for denial of payment of claims.

Approximately 1.9 million Florida residents have been defined as indigent. Of these, one third (613,000 — 330,000 children and 283,000 adults) will qualify for Medicaid enrollment during 1988. Thus, two thirds of the indigent population will lack medical coverage during the next year.

Eligibility criteria for Medicaid assistance have always been stringent. Prior to October 1, 1987, monthly incomes less than $312 for a family of four,

Table 1.—HRS/Medicaid Offices throughout Florida.

DISTRICT	LOCALE	PHONE
1	Pensacola	904-435-8867
2	Tallahassee	904-487-2272
3	Gainesville	904-395-1055
4	Jacksonville	904-723-2047
5	St. Petersburg	813-576-0035
6	Tampa	813-272-3720
7	Orlando	305-423-6251
8	Ft. Myers	813-936-2211
9	West Palm Beach	305-837-5112
10	Ft. Lauderdale	305-467-4405
11	Miami	305-377-5148

or $881 for a nursing home inpatient, or $354 for an elderly indigent or social security disability recipient were required to qualify for funds. Only the most destitute of individuals could, therefore, receive Medicaid. In contrast the federal definition of an indigent family of four is one with less than $11,200 per year. The Florida rules for Medicaid sponsorship have been established by the Legislature and not by HRS.

Liberalization of the Medicaid eligibility requirements was the first reform of the 1987 Indigent Health Care Act and will expand coverage to an additional 75,000 people. Income level criteria were increased to 90% of the federal poverty level for the elderly and disabled, and to 100% of the federal poverty level for pregnant women ($5,700 for a single woman) and children younger than two years of age. These changes will permit 19,000 elderly and disabled, 18,000 pregnant women, and 37,000 children who were ineligible under the previous law to receive Medicaid this year.

Revised Medicaid reimbursement schedule ● The second major change in the Indigent Health Care Act of 1987 was acknowledgment that payment was inadequate for services by participating physicians. The Legislature directed HRS to formulate a five-year plan in which Medicaid fees for doctors' services and diagnostic procedures would be raised to a level that matched the 50th percentile of the Medicare reimbursement fee schedule. The initial emphasis was directed toward increasing primary pediatric and obstetrical care to Medicaid enrollees and to encourage preventive as well as episodic, sick care. Early and periodic screening, diagnosis and treatment (EPSDT services, procedure code W9881) will be increased to $30 per screening visit. Additionally the number of allowable screening visits for infants and children will be increased from 16 to 20 visits up to age 20. For the first time adult health screening will be reimbursed. Such screening will include a history, physical examination, visual and hearing acuity screening, assessment of dietary habits, and specified laboratory procedures. Reimbursement is established at $35 but all components of the screen, including required laboratory services, must be completed; this fee is a bit austere but much of the work can be conducted by nursing staff. A special form (HCFA-1500) using procedure code W9606 must be completed for reimbursement of this service.

Table 2 lists the new reimbursement schedules that became effective October 1, 1987. Some of these fees have been significantly increased. Code 90020, which is used for a comprehensive new patient evaluation, has been increased from $15 to $50; this figure is respectable and will cover the cost of providing such services. Follow-up visit fees (codes 90050 and 90060 which designate limited and intermediate services for established patients) have been increased over 100%. These increases have been motivated by the realization that preventive care and early intervention in treating chronic conditions such as hypertension and diabetes will ultimately reduce health care

Table 2.—Revised Fees Enabled by the 1987 Indigent Care Act.

NEW PATIENT	PREVIOUS FEE	NEW FEE
90000 - Brief service	$15	$30
90010 - Limited service	15	30
90015 - Intermediate service	15	35
90017 - Extended service	15	44.50
90020 - Comprehensive service	15	50
ESTABLISHED PATIENT		
90030 - Minimal service	10	12
90040 - Brief service	10	21.50
90050 - Limited service	10	21.50
90060 - Intermediate service	10	25
90070 - Extended service	10	30
90080 - Comprehensive service	10	45
NEONATOLOGY SERVICES		
99160 - Initial critical care each hour	50	60
99162 - Additional 30 minutes (total of above cannot exceed 2 hrs. per day)	25	30
99171 - Critical care, brief follow-up evaluation and treatment of same illness	15	50
99172 - Limited exam evaluation and/or treatment same illness	20	65
99173 - Intermediate exam	20	80
99174 - Extended re-exam	25	100

expenditure. The increases have been designed to enable primary care and pediatric physicians with the financial capability to care for the Medicaid patient and to encourage greater participation by such physicians in the Medicaid system.

Obstetrical services will be paid at $800 for total care for the low medical risk patient and $1,200 for the high risk patient. These fees include pre- and postpartum care as well as delivery care. A minimum of ten visits for low risk, antepartum care and 15 visits for high risk care must be provided to qualify for reimbursement of the total fee. Some patients will delay care until late in the pregnancy and will not be available for ten or 15 visits; physicians will be reimbursed on a pro rata basis for such patients. Other pregnant women may receive delivery and prepartum care by different physicians; fractionation of the fees into separate components will be made in such cases.

Fees for laboratory and x-ray procedures and for surgical and other medical services not listed in the tables will be paid at the rates that prevailed prior to October 1, 1987. It is the intention of HRS to have these latter fees increased over the next five years but the timing of the increases is dependent upon legislative fiat.

The physician's guide to the Medicaid system ● Those of us who have attempted to work with the Medicaid system over the past decade have suspected that the effort involved in obtaining reasonable reimbursement for our services was similar to the effort involved in trying to grab hold of a shimmering vapor. We have been frustrated with the fusillade of paperwork, with the back-and-forth shuttling of claim forms, and the anonymous and unexplained denials of reimbursement that appear on Medicaid voucher forms. Many of us have previously attempted to machete our way through the bureaucratic thickets so that we can master the system, allowing us to properly care for the indigent patient. Most of us have failed. We have been checkmated and discomfited. Our ideals have been defiled; we have become enraged and our rage has turned corrosive. Rather than rave and rant at the regulatory or legislative potentates who have been responsible for the fecklessness of the indigent care delivery system in Florida, we further contuse the system by abandoning it rather than changing it. Many physicians remain cynical despite the recent legislative changes. The cynicism in many cases seems justified. For instance, I ordered a computer printout of my experiences with Medicaid claims over the past 18 months. I found that I was reimbursed at a rate of 3 cents on every dollar of charges submitted. The miniscule rate of reimbursement is due to the fact that over 90% of the services rendered are disallowed any reimbursement — yet no cause for the disallowance is mentioned on the payment voucher. This experience does not differ from the anecdotal protestations of many of our colleagues. Others feel cheated when they have repeatedly had a claim rejected for one or another clerical peccadillo and, while repeatedly resubmitting serial editions of the claim form, have observed the allowable six month period for requesting payment expire, thereby negating the legitimacy of the claim and its potential for payment.

The major problem with Medicaid is an apparently capricious denial of payment for services rendered.

Still other doctors proclaim Medicaid hypocrisy when HRS advertises reimbursement of $15 for an office visit, yet rarely, if ever, pays more than $10 for a visit.

Driven by this thunderstorm of complaints, I sallied forth to Tallahassee to speak with the executives of the Medicaid system. I expected to find a covey of disinterested and mentally squalid individuals emotionally detached from the problems of providing medical care to the poor of Florida. I was disarmed by the cordiality and professionalism of the reception granted me. First, these individuals sacrificed an evening during the height of the pre-Christmas season to listen to and answer my critiques and queries. Secondly, their expressed dedication to moulding and operating an effective system of indigent health care far surpassed any I have ever observed in the physician ranks. Third, they outlined for me a system for making the Medicaid program work for doctors and their Medicaid-eligible patients. Fourth, they followed up my visit by sending a specialist to my office to analyze the problems I was experiencing and to suggest means of correcting those difficulties.

The major problem with Medicaid is an apparently capricious denial of payment for services rendered. Medicaid officials state that the denial system is not random, nor irresponsible. Although 24% of all claims are categorically denied, the reasons for most of these denials are clear:

1. The patient may not be entitled to Medicaid benefits. Each patient is issued a Medicaid card every month. The regular card is *white and green* and its expiration date is clearly stated. The office staff should confirm the patient's eligibility at the time of the office visit by checking the card. In south Florida, 31,000 patients are enrolled in HMOs or other prepaid health schemes which make the patient ineligible for private practice care. These patients have a *blue* Medicaid card.
2. The provider number is listed incorrectly on the Medicaid form.
3. The beneficiary number is listed incorrectly on the Medicaid form.
4. The diagnostic code is not listed on the form correctly. Each service rendered to the same

patient, even if different services were given on the same day, needs to have a diagnostic code appended to it.

5. The diagnostic codes for Florida Medicaid may not coincide or be identical to codes pertaining to the same services that are acceptable by Medicare or by other insurance companies. Florida Medicaid is using a CPT code series that was current in 1985; the code list is outdated for other insurance vendors. The billing clerk or front office staff must obtain and enter the correct code from the Medicaid *Physician Services Manual*, which is obtainable from your local HRS office for $5.
6. The date of service must be listed.
7. The claim must be submitted within six months of the date of service.
8. Services rendered in consultation must list the name of the consulting physician.
9. The correct HCFA billing form for Medicaid services must be submitted. Superbills and other standardized insurance forms are unacceptable (apparently this is a federal and not an HRS regulation).
10. The unreimbursed 20% of the total charges of services rendered to patients insured by both Medicare and Medicaid that the patient usually must pay on assigned Medicare claims will customarily not be reimbursed. The Medicare reimbursement amount usually exceeds the Medicaid reimbursement fee. Thus this 20% will not be honored. An exception occurs early in the calendar year when the patient has not met the annual Medicare deductible.

Adherence to the above details will allegedly justify payment to the doctor of any claims for Medicaid patients. Properly completed claims forms will be reimbursed within nine business days. Doctors who treat a significant number of Medicaid patients may want to explore the use of electronic claims processing. This system should obviate the rejection of legitimate claims and hasten the time of payment.

Rejected claims should be checked for compliance with the above details. If a claim is disallowed, check the Medicaid manual. If the claim still is refused contact the E.D.S. office in your district by a WATS phone call for an appeal of the problem (Table 1). If that effort fails, call Mrs. Kim Corsmeir, Chief of Medicaid Provider and Consumer Relations in Tallahassee.

The February, 1987, FMA Journal outlined legislative proposals for enhancing indigent medical care; the legislature responded with a package closely following many of the proposals. Care of the indigent through local public health care agencies was expanded. Medicaid eligibility was stretched to care for more people; reimbursement fee schedules for primary care, pediatric and obstetrical services were raised to reasonable levels, and funds for experimental projects of providing indigent care were allocated. A totally satisfactory package was not granted but that is understandable with the limited resources available to the state. The FMA has provided leadership in proposing reform. The Legislature has responded with an economic package that is reasonable to the majority of doctors that might care for these patients. The administrative staff at HRS appears to be helpful and enthusiastic in its support of the success of the system.

The February, 1987, FMA Journal outlined legislative proposals for enhancing indigent medical care; the Legislature responded with a package closely following many of the proposals.

It is the obligation of the physicians of the state to participate in the revised Medicaid program to assure its success. There no longer exists an economic reason to refuse to participate. As physicians we have an ethical obligation to provide care for the needy. As politically savvy and sociologically responsible members of society we would be foolish to avoid participation. If the Medicaid system fails to operate as designed, we can protest to the Legislature to assure its appropriate management.

Acknowledgments

I would like to thank the following officials of Medicaid for providing me with their time and the wisdom of their expertise during an evening three days before Christmas: Tom Arnold, Acting Director of the state Medicaid program; Tom Wallace, Chief of the Medicaid Program Analysis — HMO section; Mrs. Kim Corsmeir, Chief of Medicaid Provider and Consumer Relations Office; Dr. John Sullenberger, Chief Medical Consultant; Ms. Donna Geller, Acting Program Director for Economic Services Program Office; Art Williams, manager in the Medical Development Section of the Physician Services Program.

Jacques R. Caldwell, M.D.
Daytona Beach

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NOTES & NEWS

Dr. Rubin Accepts Presidency of National Academy

Melvin Rubin, M.D., professor and chairman of ophthalmology at the University of Florida College of Medicine, takes office in January as president of the American Academy of Ophthalmology.

Dr. Rubin succeeds Dr. Arnall Patz, of Johns Hopkins University School of Medicine, as head of the preeminent worldwide organization of more than 14,000 eye specialists.

Following his year as president, Dr. Rubin will serve on the academy's board of directors for three years.

Known internationally for his work as a clinician, author, lecturer and teacher, Dr. Rubin has served as chairman of UF's Department of Ophthalmology since 1978 and has been with the faculty for 24 years. He is best known for his accomplishments in research and treatment of eye diseases affecting the retina and the vitreous, and for his teaching in optics, visual refraction and color vision abnormalities. He is the author of five textbooks, one of which was selected as "best medical book of 1979" by the American Medical Writers Association.

At the national level, Dr. Rubin has served as chairman of the American Board of Ophthalmology and as president of the Association for Research Vision and Ophthalmology which is the nation's largest eye research organization.

Dr. Collins Reelected to Preventive Medicine Board

Terence Collins, M.D., associate professor of community health and family medicine at the University of Florida College of Medicine, has been selected for a second term as vice chairman for preventive medicine and public health by the American Board of Preventive Medicine. He also has been reelected president of the North Central Florida Health Planning Council for 1987-1988.

The preventive medicine board is responsible for certifying preventive medicine specialists. As a board member, Dr. Collins helps review the credentials of physicians who apply for board certification.

The health council deals with regional health planning for 16 North Florida counties. Dr. Collins has been president of the council for the past two years.

He has been a UF medical faculty member since 1981.

Dr. Brennan Recipient of Allergy Award

The American College of Allergists (ACA) has conferred its highest award on a Boca Raton allergist.

Robert J. Brennan, M.D., received ACA's "Fellow Distinguished Award" at ACA's recent 44th Annual Congress, which drew more than 1,200 physicians to Boston for five days of scientific presentations in the field of allergy and immunology.

The "Fellow Distinguished Award" is presented each year to physicians who have exhibited outstanding dedication and leadership in the field of allergy and immunology.

Dr. Brennan, who was lauded as a "physician, lawyer, legislator and negotiator," represented allergists for many years in the American Medical Association's House of Delegates. He also was a member of the committee that organized the American Board of Allergy & Immunology, a conjoint board of the American Board of Internal Medicine and the American Board of Pediatrics.

A former second vice president and member of the board of regents of ACA, Dr. Brennan also is a past

president of the American Association for Clinical Immunology and Allergy and of the Florida Allergy Society.

Currently, he is a member of the Judicial Council of the Florida Medical Association, which he also represents on the Board of Directors of the State of Florida Medical Malpractice Joint Underwriting Association.

Dr. Brennan received medical and law degrees from the University of Illinois.

The American College of Allergists is a 3,400-member association representing practicing allergists in the United States, Canada and 52 other countries. ACA works to promote the quality of allergy care, education and research.

Dr. Toskes Named to National Examining Board in Internal Medicine

Phillip P. Toskes, M.D., director of the Division of Gastroenterology, Hepatology and Nutrition at the University of Florida College of Medicine, has been appointed to a six-year term on the American Board of Internal Medicine.

Dr. Toskes, who also is chief of the gastroenterology section at the Gainesville Veterans Administration Medical Center, will help develop the questions in gastroenterology to be used in the national board examinations in the specialty of internal medicine. He also will be concerned with the development of standards for accreditation in gastroenterology.

Dr. Toskes recently completed a three-year term on the training and education committee of the American Gastroenterological Association. For the past two years, he has chaired the National Institutes of Health Study Section concerned with training grants and career awards in gastroenterology and nutrition. He also has written a position paper for the American Gastroenterological Association in clinical and research training in gastroenterology.

DEAN'S MESSAGE

Introducing New USF Medical Center Leaders

The USF Medical Center, now in its 16th year, has gained a new vice president for health sciences and a new dean of the College of Nursing. Two new department chairs have also joined the College of Medicine faculty.

Ronald P. Kaufman, M.D., came to USF on September 1. Formerly vice president for health sciences and executive dean at the George Washington University School of Medicine in Washington, D.C., Vice President Kaufman brings to USF a broad base of experience, having been at various times a private internist, medical director, hospital administrator, medical school dean and academic vice president of a huge medical complex.

Dr. Kaufman has set as his initial priorities to realign the separate responsibilities of the medical college dean and the vice president for health sciences, to select a new dean for the College of Medicine, and to develop a strategic plan for the Health Science Center. These priorities reflect his preference for the long-term view and his willingness to invest time in finding long-term solutions to the potential problems of a rapidly growing metropolitan academic medical center.

Last March Judith A. Plawecki, R.N., Ph.D., became dean of the College of Nursing. Like Dr. Kaufman, Dean Plawecki brings an ideal mix of training and experience in the field of health care delivery. She has strong training in educational administration and in nursing care. And her nursing experience is equally extensive in pediatric and gerontological nursing.

Dr. Plawecki has already communicated to her faculty that she expects ongoing bona fide research involving graduate and undergraduate students. "I hope to instill in our graduates the lifelong process of critical inquiry," she says. "Nurses need to continually re-evaluate how we deliver nursing care in view of the constant technological advances in medicine and the increasing complexity of ethical decisions nurses now must make. Because of DRGs and HMOs, hospital stays are shorter and patients are sicker. Nurses are caring for the same number of patients, but they are more seriously ill. Home nursing care and nursing in extended care facilities have changed similarly. A lot of nursing in the past was based on intuition. Now we're looking at research validating what we do."

A strong advocate of baccalaureate and masters studies in nursing, Dr. Plawecki was dean of the schools of nursing at the University of North Dakota and Lewis University (near Chicago). The USF college offers courses at four campuses: Tampa, St. Petersburg, Sarasota and Ft. Myers. Students gain clinical experience in nearly 100 facilities in these communities.

In the College of Medicine, Diane H. Russell, Ph.D., has accepted the chairmanship of the Department of Pharmacology and John B. Downs, M.D., is the new chairman of the Department of Anesthesiology.

The first woman to chair an academic department in the college, Dr. Russell is a nationally recognized scientist whose research has focused on the regulation of the growth of normal and cancer

cells. Currently Professor of Pharmacology and of Molecular and Cellular Biology at the University of Arizona College of Medicine, she will join the USF faculty in the spring.

Dr. Downs is a graduate and former faculty member of the University of Florida College of Medicine. Now Professor and Vice Chairman of Anesthesiology at Ohio State University, he has special certification in critical care medicine. Dr. Downs will direct the anesthesiology units at Tampa General Hospital and Moffitt Cancer Center, and he was jointly recruited by the USF College of Medicine and Tampa General. He is also actively involved in academic medicine and research, having published well over 100 scientific journal articles.

Sally B. Padgett
Office of the Vice President
USF Health Science Center

ENCORES!

HMOs: An Idea Whose Time Has Passed

During a typical busy afternoon, I received a call from the office of an HMO plan in which I was a participating provider. They instructed me to phone the emergency room of a hospital at which I do not have privileges and have them transfer a potentially unstable patient to another facility. This patient had recently switched from another HMO plan which had gone bankrupt and was now assigned to me, but had never been to my office. Of course, I refused, in no uncertain terms, but at the same time I realized that this was not the first inappropriate demand made on my patient care by this organization.

In a previous editorial, I wrote about a patient who developed complications after early hospital discharge and was then denied readmission. Subsequently I was informed that this young man had been fired from his job for absences related to his illness and was not even covered by the plan. Therefore the hospital was not being paid for either admission despite careful pre-admission certification.

On another occasion, my staff spent well over three hours trying to arrange approval of a cardiac catheterization for a five-year-old at Jackson Memorial Hospital, which was a non-participating hospital.

As the evidence mounted, so did my staff's resentment of HMO paperwork, phone calls and refusals. I found that a larger amount of office visits were being devoted to HMO patients even though they represented less than two percent of our patient panel. The prevalence of their visits along with the hassles of providing their care, prompted me to place some calls to colleagues.

The response was the same from an OB-GYN, ENT, cardiologist and a fellow family physician. They were all in the process of or anxious to terminate their HMO contracts. The shared relief of common frustrations only served to accelerate this process. After covering for me during a week's vacation, my partner realized this same problem when all the HMO patients visited him that week. We contacted the main office as per our contract and gave our 90 days notice.

Prior to terminating our contract, we met with a very personable representative of the HMO to discuss our problems. He had an MBA rather than a medical degree and the discussion focused on the company's burgeoning portfolio and assets rather than quality health care and physician service. This also reflected the similar experiences of my colleagues.

HMOs may be the wave of the future but even the man who coined the term HMO, Paul Elwood, now believes that they will take a much more traditional form. Unfortunately, many of the largest HMOs have reaped profits from skimping on patient care, convenience, freedom of choice and the physician's time and goodwill. As you can see from the lead article in this issue, physicians are realizing the tremendous shortcomings of HMOs and the financial and organizational sacrifices required to participate. It is obvious that health care financing in the United States is uneven and erratic, but I am convinced that HMOs are not the solution. They only serve to further undermine the physician-patient relationship and line the pockets of thousands of MBAs across the country.

Perhaps the most exciting follow-up to our decision to discontinue participation in the plan has been this: many of the HMO subscribers that we regretted losing as patients have chosen to make other financial arrangements, in order to remain our patients.

Richard Hays, M.D.

Reprinted with permission from *On Call*, Palm Beach County Medical Society Newsletter, December 1987.

Giving Up the Arquebus

When Sir Edmund Hillary gave his famous response to the great question about why, at some expense and risk, he should have clamored up Mount Everest, he was expressing a particularly Western attitude to nature and our conquest of it. On the other hand, the Japanese, left to their own devices, simply admired Mount Fuji, contemplating its elegant contours in different lights and perspectives, but leaving the climbing of it to a date remarkably late in their history.

I have myself always accepted Hillary's reply as defining something inevitable in our nature. I accept furthermore the technology which is its corollary with a gratitude laced only with a rather modest degree of passive reservation.

Our civilization has, after all, pretty much defined itself by a certain inevitability in the "March of Progress" of whatever sort, including the atom-smashing, nature-trodding, tree-cutting, concrete pouring kind. Anyone who much breathes other than outright ribald Progress or its restraint is somehow suspect, and the burden of proof to suggest alternatives is on him who cavils. Nor can the clock be "turned back"; nuclear weapons cannot be uninvented; we must swallow whatever progress hands us on its sometimes doleful platter.

But flesh is weak, and one gets accustomed to comfort. I rather like electricity and air conditioning; I prefer shopping at Publix to seeking nuts in the wet woods. And so I blandly accept the blessings of progress, and wink at its failures. I am even inclined to place a certain amount of faith in nuclear weaponry, at least as manifested by the Pax Atomica of the last 40 years.

But I have finally drawn the line. I am pushed to the brink, having read in the paper that we now have at hand the technology permitting real men to have real babies. And I beg to demur.

Granted I may now be thought a fuddy-duddy reactionary, rather like those who said early in our century that if God had wanted us to fly He would have given us wings; and what is the difference between pseudo-wings and pseudo-wombs? And of course there will be an exodus of men flying forth from the woodwork, to appear on the Oprah Winfrey show describing in piteous terms how all their lives they have felt less as men because they couldn't have a baby; they will with heart-felt feeling say how it is this experience that men have been so pathetically denied, and which has rendered them less than complete as human beings. I will be tempted to throw bricks at them, and will myself refuse to have a baby even if my wife wants one.

Having read about this particular great leap for mankind, I take courage in my own public denial of it, hoping possibly to find within me a new capacity to cry surcease to other technological marvels. I doubt that I will want to give up air conditioning, nor yet trade back the horse for the automobile. On the other hand I am ready to get rid of the airplane, which has simply shrunk the world and deprived real travel of its interest and curiosity. Television may go, but I am prepared to keep the radio. The telephone is allowed for business and urgent need, but more personal communications should once again be restored to the literacy of letters. As with male motherhood I renounce absolutely the new, freon-charged toothpaste dispenser, which is heavy, cost-ineffective, and very likely ozone-destructive.

But is it possible, one might ask, to "turn back the clock", or be thus selective in what as a civilization we may choose to keep or let go? One feels almost powerless in the face of Progress because we are so overwhelmed by its innumerable manifestations, and with so few examples of our ability to choose and withhold. But it is possible! It has been done! As such, it becomes an historically compelling fact that a highly sophisticated culture, with a technological prowess then as now equal to or better than any of its time, did in fact turn away from a technologically advanced innovation in relation to which it had become outstanding in its production and use. I revert, of course, to the Japanese.

In 1543 there arrived to the shores of Japan the first Portuguese, bearing with them the arquebus and ammunition. Within a decade the Japanese had fully mastered the production of such weapons, refining them beyond even the European genius, and were exporting exquisite examples of their weaponry all over Asia. The Samurai took up the gun, became masters of its art as much as of the bow and sword, so that by the mid-1540's all the vassals of Lord Tokitaka "trained with the new weapon, and so . . . out of every hundred shots they fired, many of them could hit the target a hundred times." Then, about 1615, they gave it up! Whatever the reasons, religious, artistic, practical, philosophic or for some subtle mixture of all these they renounced absolutely the gun, its use and production. When Perry "opened" Japan almost 250 years later he stepped into a world where the gun did not exist.

The example is curious; but one wonders what kind of cultural will and societal effort it takes to so command a technology rather than be its passive slave. The latter is easier to be; the choice to do something is often easier than to not: if it is high, simply climb it; if it is low, plumb it; if it is do-able, do it even if it flies so in the face of realities as to fly indeed, or to give men their own babies, or to keep people alive when hope is gone.

And so . . . as men become mothers . . . I ask myself if after all we really need always to do things just because they "are there" and can be done. And, often enough at that, at great expense . . .

Charles Moore, M.D.

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References:
1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987

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- **Safe in angina with coexisting hypertension, COPD, asthma, or PVD**[1,3,5,6]

60 mg GREATER DOSAGE FLEXIBILITY 90/120 mg

*CARDIZEM® (diltiazem HCl) is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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CARDIZEM® ANTIANGINAL PROTECTION PLUS SAFETY

diltiazem HCl/Marion

Usual maintenance dosage range: 180-360 mg/day

Rx

Cardizem®
(diltiazem HCl)

☐ 60 mg ☐ 90 mg
☐ 120 mg

Sig: tid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 9/86

See complete Professional Use Information before prescribing

References: 1. Schroeder JS: Mod Med 1982;50(Sept):94-116. **2.** Cahn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **3.** O'Rourke RA: Am J Cardiol 1985;56:34H-40H. **4.** McColl D, Walsh RA, Frohlich ED, et al: Curr Probl Cardiol 1985;10(8):6-80. **5.** Frishman WH, Charlop S, Goldberger J, et al: Am J Cardiol 1985;56:41H-46H. **6.** Shapiro W: Consultant 1984;24(Dec):150-159. **7.** D'Haro MJ, Khurmi NS, Bowles MJ, et al: Am J Cardiol 1984;54:477-481. **8.** Strauss WE, McIntyre KM, Parisi AF, et al: Am J Cardiol 1982;49:560-566. **9.** Feldman RL, Pepine CJ, Whittle J, et al: Am J Cardiol 1982;49:554-559.

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Giving It Away

Some days she is knock-down gorgeous; other times her children make her drop them a block from school so no one will know she's their mom. Pearls of wisdom fall from her mouth and then she shows up for her logic exam — the day *after* the test. She's a bit of a perfectionist; it shows in her home, her career, her family. She is also human with all those attendant failings and no one knows that more than she.

Many hours a month are given away to others through her church and civic groups. Her children's school couldn't run without the chili suppers, garage sales, and shoring up of the teacher that she does. She may just also happen to be a doctor, a lawyer, (I don't know of any Indian chiefs) nurse, architect, teacher, or a variety of entrepreneur. She may also be a he. Put it all together and you have a small insight into the kind of person that makes up your local medical auxiliary. It is a person who gives and gives and somehow reaches down and gives a little bit more. Because it is needed.

But there comes a time when the reserve on which we draw is gone. We fear we will wake up and find we have given ourselves away and there is nothing left of the person we once were. We have forgotten to take the time to replenish ourselves so that we may always have — to give. And that is the hard part. As members of a medical community we are natural nurturers and givers to others. We must also learn to nurture ourselves and indeed it is crucial. Medicine has never been an easy profession but in our present situation it feels a little like being in a combat zone. The doctor does not practice in a vacuum; almost all have a spouse and children and when that angry patient vents his or her spleen or that lawyer's request for records crosses the desk, more than the doctor is being shot at from the hip. Those of us on the periphery take it too.

As Liaison Editor this year, my main aim will be a personal sharing of the auxiliary; the people who make it up, some of their concerns and stresses, where the auxiliary is going and where it has been, and the direction we would *like* to see it take. I hope this page will provide a little nurturing by means of letting medical family members know that they are not alone, and by providing a catalyst for discussion among members of both the medical society and the auxiliary on how we can help ourselves and each other. We all have moments of considering ditch digging as a viable alternate profession.

We have so much to gain. Let 1988 be a year of communication to better understand our needs, and through collaboration on all parts — husbands, wives, children, physicians and auxiliary members — reach our goal of being allowed to do what the medical community does best — helping others.

Mrs. Charles E. (Lynn) Moore
Auxiliary Liaison Editor

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

FEBRUARY

13th Annual Review and Recent Practical Advances in Pathology, January 31 through February 5, Fountainbleu Hotel, Miami Beach. Contact: Marie Valdes-Dapena, M.D. (305) 549-6437.

Current Concepts in Cardiovascular Disease, February 1-5, Buena Vista Palace Hotel, Orlando. Contact: Clarence Shub, M.D. (507) 284-2511.

Vail Symposium in Intensive Care, February 6-13, Vail, Colorado. Contact: Brian Craythorne, M.D. (305) 547-6411.

Current Clinical Concepts in Reproductive Endocrinology and Perinatology, February 8-10, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

13th Annual Review and Recent Practical Advances in Pathology February 1-5, Miami Beach, Fontainbleau Hotel, Contact: Marie Valdes-Dapena, M.D., (305) 549-6437.

Current Concepts in Cardiovascular Disease February 1-5, Orlando, Palace Hotel, Contact: Clarence Shub, M.D., (507) 284-2511.

Neurological Update 1988 February 3-7, Bal Harbour, Sheraton Bal Harbour, Contact: Gloria Allington, (305) 547-6716.

Symposium in Intensive Care February 6-13, Vail, Colorado, Contact: Brian Craythorne, M.D., (305) 547-6411.

Current Clinical Concepts in Reproductive Endocrinology and Perinatology, February 8 - 10, West Palm Beach, Good Samaritan Hospital, Contact; Laura Lyons, (305) 650-6236.

20th Miami Winter Symposium, February 8-12, Hyatt Regency, Miami. Contact: W.J. Whelan, M.D., University of Miami, Dept. of Biochemistry (305) 547-6265.

Risk Factors for the Development of Skin Cancer and its Treatment, February 9, University of Miami, Miami. Contact: Larry D. Garland, M.D. (305) 547-4477.

Cardiology at Walt Disney World, February 11-14, Contemporary Resort Hotel, Lake Buena Vista. Contact: Scott Greenwood, M.D. (305) 843-1330.

14th Annual Fred J. Woods Lecture Series, February 12-13, St. Josephs Hospital, Tampa. Contact: Ralph Jensen, M.D. (813) 877-3682.

Alcohol and Substance Abuse, Miami Airport Hotel, Miami. Contact: Raphael S. Good, M.D. (305) 549-7661.

Magnetic Resonance Imaging, February 15-19, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Conference on the Beach, February 15-20, Holiday Inn Surfside, Daytona Beach. Contact: William G. Tomson, M.D. (904) 254-4167.

Special Topics in Diabetes Management, February 16, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Reproductive Organs Abnormalities Symposium, February 17-20, Vail, Colorado. Contact: James Ingram, M.D. (813) 974-2088.

Sarasota Vitreoretinal Update Course, February 18-20, Colony Beach Resort, Longboat Key. Contact: James Kingham, M.D. (813) 921-5335.

10th Annual Pulmonary Winter Course, February 18-21, Contemporary Hotel, Lake Buena Vista. Contact: Richard T. Doggett (904) 743-2933.

Pediatrics for the Practitioner: Update on Pulmonary Diseases, Sheraton Tampa East, Tampa. Contact: Herbert H. Pomerance, M.D. (813) 974-4214.

Dementia: Current Research and Clinical Aspects, Radisson Plaza Hotel, Orlando. Contact: Eric Pfeiffer, M.D. (813) 974-4355.

Health Care for the Elderly, February 19-20, Radisson Hotel, Orlando. Contact: Eric Pfeiffer, M.D., USF Med. Center (813) 974-4355.

Pediatric Dermatology CME Tour, February 19-March 7, India. Contact: Mr. Frank Martin 1-800-243-5030

Eyelid Surgery: A Basic Course for the Practicing Physician, February 20, USF College of Med., Tampa. Contact: J. Justin Older, M.D. (813) 971-3846.

Radiology in Seville, February 20-27, Seville, Spain. Contact: Lucy R. Kelley (305) 674-2681.

Neuroradiology Seminar, Radisson Plaza Hotel, Orlando. Contact: Rick D. Mace (305) 897-1944

Breast and Thyroid Surgery: Current Controversies and Management, February 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

15th Annual Symposium in Pediatric Nephrology, February 21-25, Sheraton Bal Harbour Hotel, Miami Beach. Contact: Pearl Seidler (305) 549-6726.

Internal Medicine 1988, February 21-26, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Magnetic Resonance Imaging, February 22-28, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Basic Trauma Life Support Provider Course, USF College of Med., Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

February Course in Electrocardiography, February 29-March 2, Marriott Hotel, Boca Raton. Contact: Jules Constant, M.D. Cardiac Study Fund, Box 114, Hiler Branch, Buffalo, NY 14223 (716) 836-5172.

MARCH

20th Teaching Conference in Clinical Cardiology, March 2-5, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., Ph.D., University of Miami (305) 547-6716.

Mid-Winter Seminar in OB/GYN, March 3-5, Don CeSar Resort, St. Petersburg. Contact: James Ingram, M.D. (813) 974-2088.

9th Annual Advances in Clinical Medicine, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

9th Annual Mammoth Mountain Emergency Medicine Ski Conference, March 6-11, Mammoth Lakes, Calif. Contact: Medical Conferences, Inc. 1-800-457-2777.

Cardiovascular and Diabetic Therapy, March 7-9, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

Wound Dressing/Retinoic Acid March 8, Univ. of Miami, Miami. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101

2nd Annual Oncology Conference, Peabody Hotel, Orlando. Contact: Wendy J. Henry (305) 897-1600.

Selected Issues in Adolescence, March 11, Harbour Island Hotel, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Breast Disease Update & Seminar, March 16-18, The Hilton, Lake Buena Vista. Contact: Esther Cohen, M.D. (305) 674-2311.

Team Management in Patient Care, March 21-22, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Pediatric Goldcoast Conference, March 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

10th Annual Family Practice Review, March 21-25 Holiday Inn Surfside, Clearwater Beach. Contact: Frances Adams (813) 893-6156.

AIDS: Defining the Process, March 24-26, Building TBA, Daytona Beach. Contact: Halifax Medical Center, Educational Services (904) 254-4169

Cancer Conference, March 25-26, Daytona Hilton, Daytona Beach. Contact: Nancy Drane, R.N. (904) 254-4212.

9th Annual Advances in Clinical Medicine, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

Board Review Course in Geriatrics, March 28 - April 1, Radisson Plaza Hotel, Orlando. Contact: Eric Pfeiffer, M.D. (813) 974-4355.

Estrogen Replacement Therapy in Pre- and Post Menopausal Females, March 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

3rd Annual Controversies in Carcinoma of the Breast, March 31-April 2, Marriott World Ctr., Orlando. Contact: Drs. Clark and King (813) 974-2538.

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PROSTATIC CANCER
The 10th Annual Oncology Update
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Cedars Seminar Center, 1295 N.W. 14th Street, Miami, Florida

COURSE DESCRIPTION:
Surgeons, urologists, oncologists and primary care physicians will explore the latest efforts in the diagnosis and management of prostatic cancer.

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CME CREDITS:
6.5 hours, Category I

ACCOMMODATIONS:
The Sheraton Brickell Point, 495 Brickell Avenue, Miami, Florida 33131. Phone (305) 373-6000. Please contact the hotel directly.

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Physicians (Before Feb. 1, 1988) – $159.
(After Feb. 1, 1988) – $184.
Nurses and Allied Professionals
(Before Feb. 1, 1988) – $70.
(After Feb. 1, 1988) – $95.

Make check payable to "Cedars Oncology Update", and mail to Cedars Medical Center, Medical Staff Office, 1400 N.W. 12th Avenue, Miami, Florida 33136.

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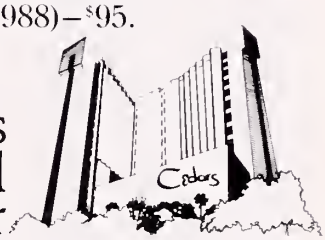

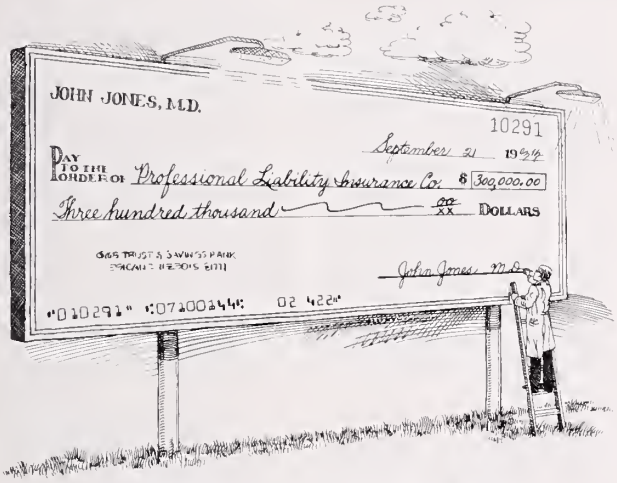

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BOARD CERTIFIED GENERAL SURGEON, as associate, private practice in Orlando. Send CV, references, photo to Box C-1366, P.O. Box 2411, Jacksonville, FL 32203.

FAMILY PRACTICE — Great Opportunity to join a busy solo practitioner in Lake Worth (West Palm Beach). Board Certification/Eligibility required. Contact Art Altbuch, M.D., 3918 Via Poinciana, Suite 5, Lake Worth, FL 33467, 305-433-1700.

BOCA RATON, FLORIDA. Active private practice in Primary Care Internal Medicine, with collectibles in excess of $400,000 needs board certified or board eligible associate now, with object to buy approximately December 1989. Write: Primary Care Internal Medicine, 153 E. Palmetto Park Road, Suite #222, Boca Raton, FL 33432.

NEUROLOGIST— Experienced Neurologist needed to join expanding 85 Physician multi-specialty medical center, in Los Angeles and Orange counties, with existing Neurologic practice. An exceptional base salary and incentive plan. Benefits include malpractice insurance, group health and life insurance. Please send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1436, Jacksonville, FL 32203.

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RADIOLOGIST NEEDED For part-time or full-time, retired to employed to read Mammograms. (305) 868-7740.

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MOLECULAR BIOLOGIST - The Department of Pathology, College of Medicine, University of Florida is seeking a molecular biologist (Ph.D. or M.D.) to fill a tenure-track position at the Assistant Professor level. Research experience in human molecular genetics and cDNA cloning is highly desirable. The successful candidate will be expected to deveop an independent research program in human molecular genetics, participate in the educational training of graduate students, and provide technical expertise for the diabetes research center. Applicants should submit curriculum vitae, plus copies of three publications which best exemplifies their work, and the names of three references to William J. Riley, M.D., Associate Professor, Department of Pathology, Box J-275, JHMHC, Gainesville, FL 32610. Recruiting deadline is 2/29/88 with approximate starting date of 7/1/88. Salary will be dependent on experience. Equal Employment Opportunity/Affirmative Action Employer.

BE/BC family physician needed immediately for busy central Florida solo family practice. Interest in Pediatrics, Gynecology preferred. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1448, Jacksonville, FL 32203.

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

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Limbitrol* (IV)
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
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FEBRUARY 1988, Vol. 75, No. 2

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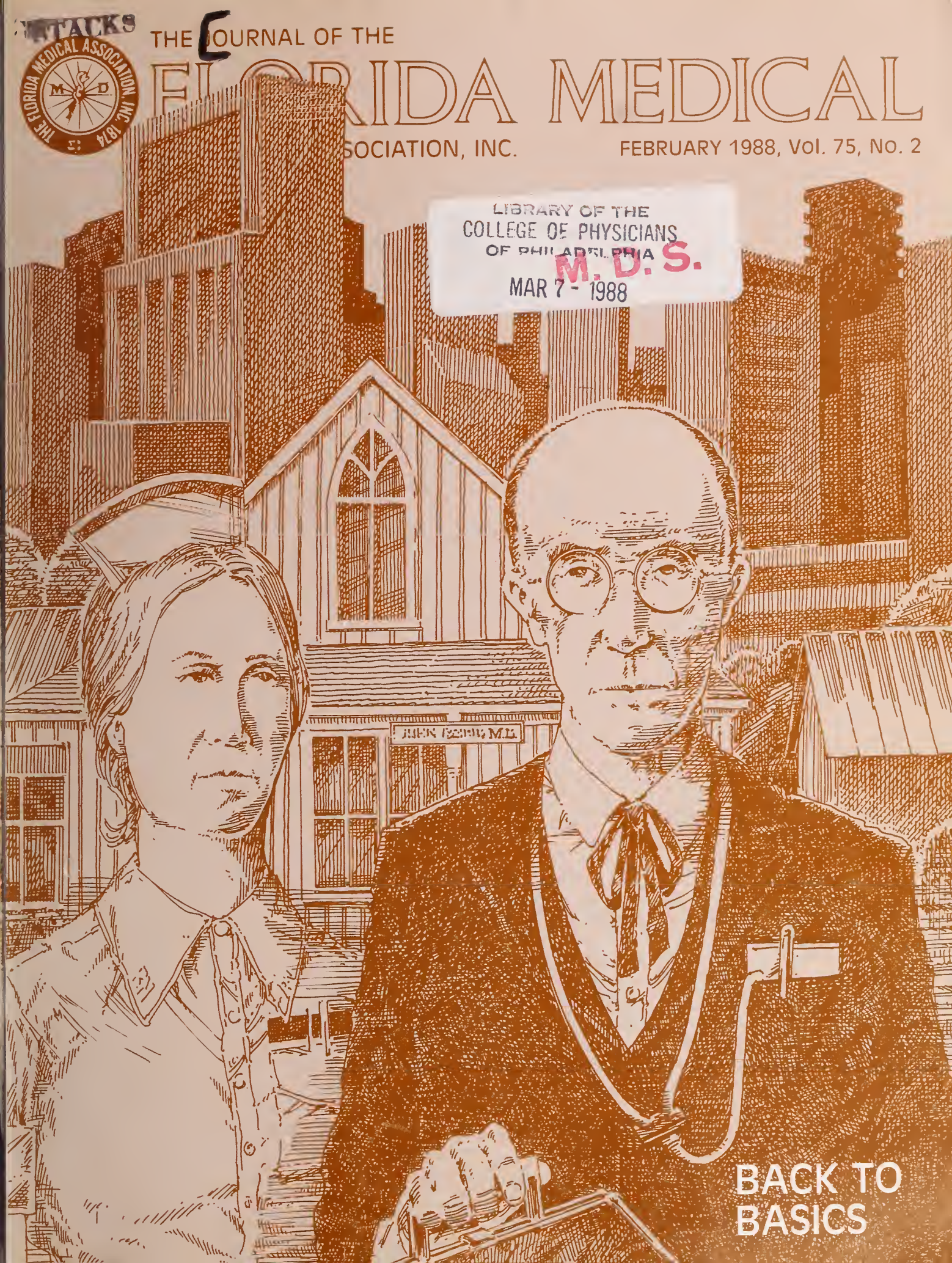

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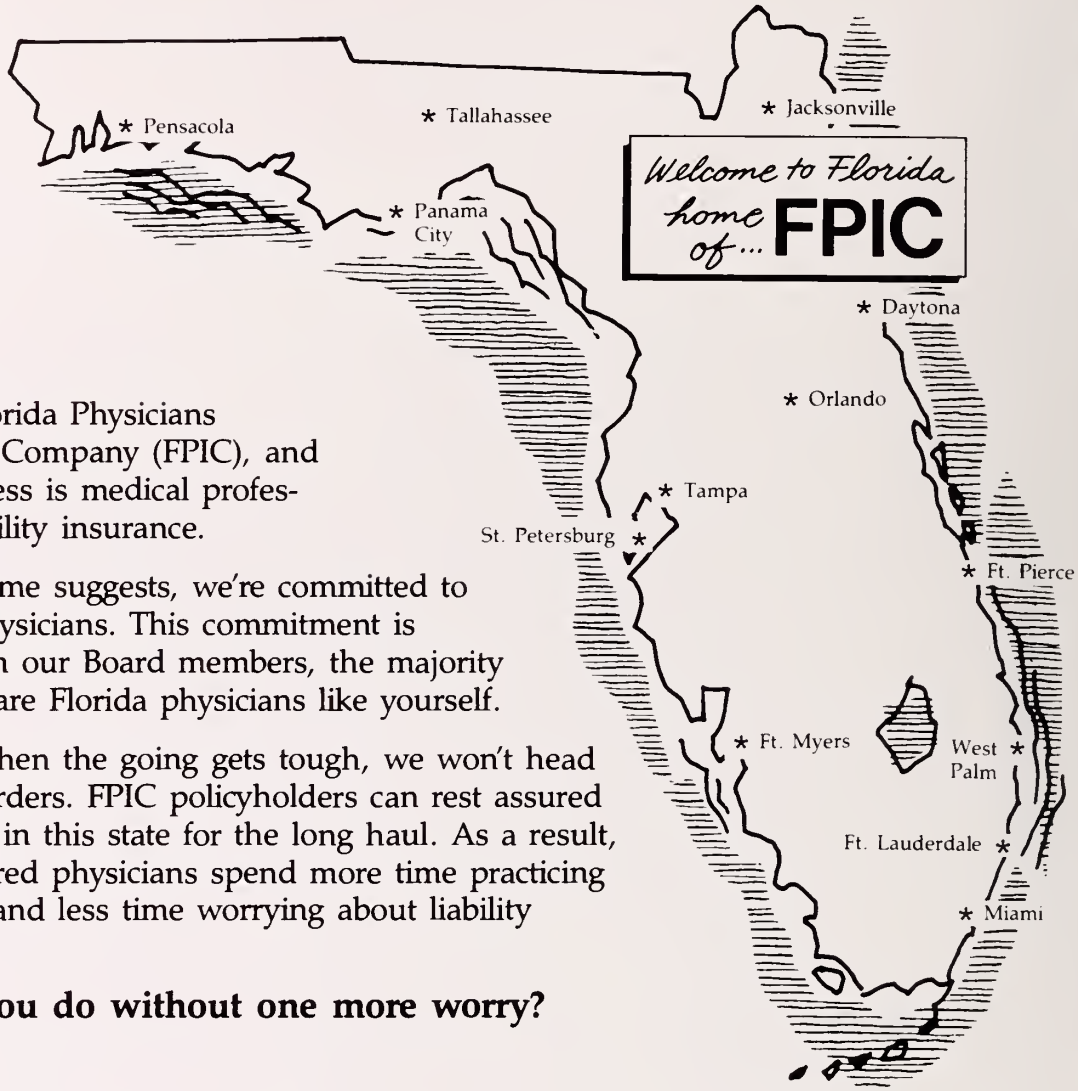

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PRNews

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February 1988 "Doctors Helping Doctors" Vol. 4 — No. 1

Here's How To Call Us . . .

The Physicians Recovery Network now has an 800 telephone number to faciliate contact with the Network's Jacksonville office. This number may be used throughout Florida Monday through Friday 8:30 a.m. to 5 p.m.

On weekends and holidays a call forwarding procedure through an answering machine insures emergencies and other problems or questions are handled.

The Network's office numbers and hours of operation are as follows:

Toll free 800 number:
800-888-8776 or 800-888-8PRN
8:30 a.m.-5 p.m. Monday through Friday excluding holidays.

24 hour service number
904-354-3397 weekdays, weekends and holidays.

Intervention Workshop Set for March 12-13

The Physicians Recovery Network's Eighth Workshop on Intervention with Impaired Physicians will be conducted in St. Petersburg on Saturday and Sunday, March 12-13.

Intervention techniques, treatment, the disease process, and recovery monitoring will be among topics covered. The program will run all day on Saturday with optional meetings of AA and NA in the evening, and until noon on Sunday.

(Continued on Next Page)

Think 'PRN'!

It *was* the FMA-FMF Impaired Physicians Committee. *Now*, it's the Physicians Recovery Network Committee, or "PRN" for short.

The Committee thought its old name was outmoded and tended to conjure up negative impressions. It believed that the emphasis should be on"recovery", a more positive term.

The Board of Governors agreed, and the name change was authorized last year.

It is believed the new name will change the public's and the medical profession's perceptions of the program and its services.

Medical Family Component Program Provides Help for Spouses of MDs

In the 1970's, through the efforts of the Florida Medical Association and its Auxiliary, the initial Committee on Impaired Physicians was formed in Florida. These early efforts in addressing impairment in health care professionals resulted in the Florida Medical Foundation's Impaired Physicians Program (now called the Physicians Recovery Network) receiving wide acceptance from the medical profession, the health care industry, state and federal agencies, and the public. The success of the Program is the direct result of the support and commitment of the leadership of the Florida Medical Association and the Auxiliary to assure excellence in health care in Florida.

It became apparent the Impaired Physicians Program needed to expand to provide services to the medical family members. In 1987, the Physicians Recovery Network Committee, through its Chairman, Guy T. Selander, authorized the expansion of services to family members and obtained funding for the project.

Florida is the first state to implement a comprehensive Medical Family Component to work separately from, but simultaneously with, a structured statewide program. The program was presented at the American Medical Association's 8th National Conference on Impaired Health Professionals in Chicago last October. This presentation was made by Mrs. Kay Orr-Goetz, the consultant for the Family Component Program. Conference Chairman Donald M. Keith, M.D., said, "We need family help groups in every state and community — helping with the family and the impaired family. I challenge the Auxiliary as I have for years — cannot you give support at a time when one of your members is at her most desperate and depressed time — after a divorce at a time when she needs friendship, her ticket of admission is withdrawn and she is summarily cast out to fend for herself?"

A number of county auxiliaries have begun to develop projects in unison with the Medical Family Component to address the critical need to assist medical families in crisis. The State Auxiliary Liaison to the Physicians Recovery Network works closely with the Family Component staff to develop avenues for the state and county auxiliaries to take an active role in providing services to medical families.

The Medical Family Component provides support and guidance to family members of health care professionals affected by chemical dependency, mental or emotional

(Continued on Next Page)

David Cushman Hired As Assistant Director

In order to perform in its expanded responsibilities, the staff of the Physicians Recovery Network (PRN) has been enlarged.

Mr. David Cushman, a former Air Force officer and a professional in personnel management and employee assistance programs, has joined PRN as Assistant Director, according to PRN Director Roger A. Goetz, M.D. In his new position, Mr. Cushman is responsible for the management of the PRN office and program administration, the recovery and monitoring process and special projects.

Mr. Cushman

A graduate of Albion College, Mr. Cushman formerly was employed by ITT Rayonier and FMC Corporation. He and his wife, Mary Jane, reside at Fernandina Beach with their two children.

The promotion of Mrs. Kriss Duckett to the position of administrative assistant also was announced. She has served as executive secretary to Dr. Goetz for more than two years.

Succeeding Mrs. Duckett as executive secretary is Ms. Judi Laflamme. Her duties include assisting the new Family Component Program.

Dr. Goetz said the staff expansion was needed to cope with a sharp increase in the new case rate, which has risen from 13 a month during the first half of 1987 to an average of 20 per month more recently.

Guidelines Are Approved for Returning to Medical Practice

To provide protection for physicians and health care institutions, the Physicians Recovery Network has developed guidelines for recovering physicians returning to hospital practice.

Each physician is to be treated individually. Factors to be considered are the type of practice the physician intends to resume, the privileges requested, the legal status of the physician's license, and relationships with law enforcement or federal regulatory agencies. Not all provisions listed below need to be applied to every physician.

Since the practice of medicine at most hospitals is a privilege rather than a right, PRN recommends that it be the physician's responsibility to provide the information requested by the hospital staff as a prerequisite for reentry. It is the recovering physician's duty to assure the public, the profession, and the hospital that he has returned to health and will continue to assume the responsibility for his own well-beling. The physician should provide:

1. A signed limited release of information waiving his/her confidentiality protections so staff of the hospital or other appropriate individuals may make inquiries. Records released through such waivers are released only to those named in the release.

2. Evidence of successful completion of all recommended treatment in a program approved by the Board of Medicine.

3. A recommendation to return to practice from the treating physician of the treatment facility.

4. The name of and report from the physician's personal physician, defined as the physician who will provide the general medical care of the recovering physician.

5. The name of and report from the monitoring physician, defined as the physician who will oversee the medical activities of the recovering physician.

6. The name of and report from the therapist who will be treating the recovering physician's specific impairment problem.

7. Evidence through personal affidavit of attendance at the following therapeutic activities:
   (a) physician recovery group
   (b) monitored aftercare group
   (c) AA/NA, if appropriate to the physician's impairment.

8. Random urine and blood samples for chemical analysis when requested and if there is any question by any member of the hospital staff. In addition, PRN may also screen appropriate individuals through a random no notice visualized urinalysis program.

9. Documentation of family or significant other involvement in the treatment process and aftercare programs supported by the family component program or other family support programs.

10. Compliance with regulations of the PRN.

11. Maintenance of chemical free lifestyle using only medications prescribed by the personal physician or the therapist.

12. Physician generated reports are the responsibility of the recovering physician and are to be reported to the medical staff, impaired physician, or credentialing committees. The frequency and intervals of these reports should be determined individually or by the extent of the physician's illness and regulatory requirements. Such reports are frequently mandated by Board order and may be critical elements in complying with probationary requirements on a physician's license. At no time in the course of these information exchanges should the physician's confidentiality be violated through the disclosure in a public meeting or to others not named in the release.

While these guidelines are not onerous or administratively burdensome, they are complex. Recovering physicians attempting to reenter a hospital staff or hospitals considering extending priviledges to such physicians may obtain advice and assistance in these matters by contacting the Physicians Recovery Network office at (904) 354-3397 or 800-888-8776.

Medical Family (Cont.)

illness through identification, intervention, referral, continuing care and education. In April of this year, Mrs. Orr-Goetz joined the Physicians Recovery Network staff to develop and implement the component program. She brings years of professional and personal experience to this challenging endeavor.

PRN and its Medical Family Component are asking all Auxilians to join in a cooperative effort, combining time and talents to work in pursuit of health medical families. County ausiliaries interested in becoming active in supporting medical families should contact Mrs. Janet Hoshead, State Auxiliary Liaison to the Physicians Recovery Network, or Mrs. Orr-Goetz through the office of the Physicians Recovery Network (904-261-7095).

Intervention (Cont.)

Application has been made to the Committee on Continuing Medical Education of the Florida Medical Foundation for approval of 12 hours of AMA Category I CME credit.

Physicians in recovery or those interested in learning how to help their fellow physicians through intervention are invited and encouraged to attend.

Additional information may be obtained by contacting Mr. Edward D. Hagan, FMA, P.O. Box 2411, Jacksonville, Fla. 32203, telephone (904) 356-1571.

Florida Is Pilot in Epidemiologic Study

Florida is one of 10 states participating in a data collection project that eventually will propvide answers to many questions about physician impairment.

The project is called Pilot Impaired Physician Epidemiologic Surveillance System (PIPESS), and it was conceived by Dr. Karl Gallegos, Director of Data and Statistics at the Caduceus Foundation in Smyrna, Ga.

Representatives of the Florida Medical Foundation's Physicians Recovery Network (PRN) recently worked with Dr. Gallegos to format data collection and input. Florida's data base will be the pilot and model for the other participating states.

The project already is beginning to identify medical specialties in which the risk of addition is highest. Predictions of disease incidence in specialty populations will make possible evaluation and treatment early in the addictive process.

Eventually, PIPESS is expected to provide:

— A capacity for accurate assessment of physician impairment;

— Definition and categorization of impairments affecting physicians;

— A base for research and development programs to reduce the frequency and prevalence of such diseases; and

— Continuing evaluation of these programs.

Almost one-third of the nation's physician population is located in the 10 PIPESS states which in addition to Florida include New Jersey, New York, Ohio, Florida, Mississippi, Tennessee, Georgia, Oklahoma, Washington and Oregon. As the project moves forward, other states will be asked to participate.

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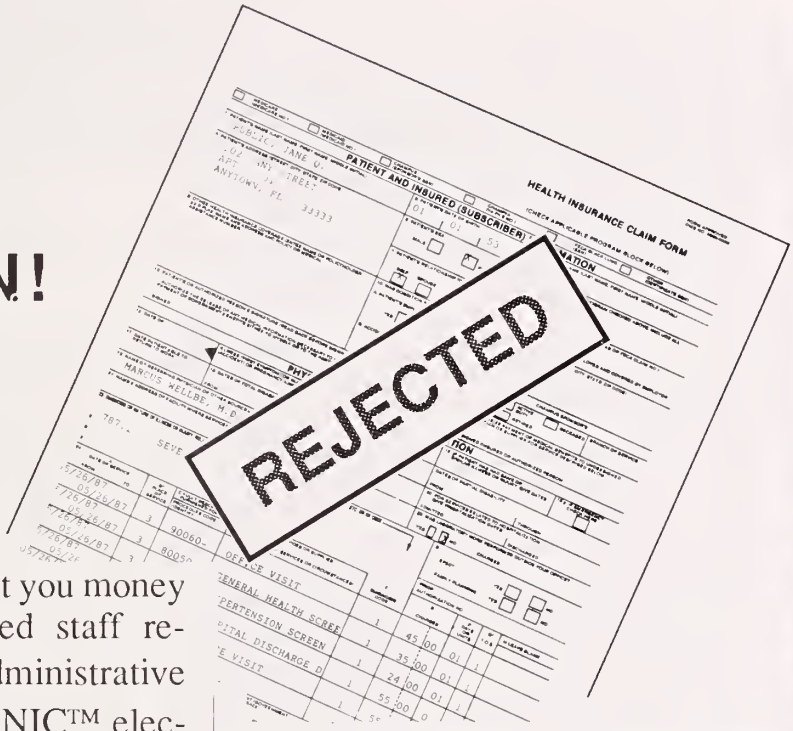

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COVER

A variation of Grant Wood's classic painting, "American Gothic," graces this month's cover of *The Journal*. The work of Jacksonville artist Chris Armstrong, the cover depicts the "Back to Basics" theme of FMA President, James G. White, M.D., as well as this month's special article by Dale Havre, M.D.

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A Semblance of Victory in Tallahassee

Since our last visit here in *The Journal*, we have made substantial progress with our PLI problem. At the January Board meeting in Orlando, we voted not to support the MIRA bill in the form it had taken via amendments. We felt we should go to Tallahassee and reinstate the $100,000/$200,000 caps, as well as prevent any other further erosion of the orginal bill.

On the opening day of the Special Session, we had an informational meeting for the visiting physicians and Auxilians, followed by a press conference on the steps of the old Capitol building. The ensuing three days proved to be grueling but exciting as our emotions went from sky-high to death-valley low. At one time, we had to deal with the Trial Bar's mandatory arbitration which would have resulted in increased premiums. The following day we had mandatory assignment for Medicaid and mandatory participation by obstetricians tacked on as amendments. Fortunately, we were successful in getting both of these removed from the bill. After passing through three committees in the House and one in the Senate and then being voted out of both bodies, the Conference Committee then met to resolve the differences. This again proved to be a roller coaster ride and when the dust settled late Thursday night, we had the final product.

During these meetings, our adversaries were omnipresent, attempting to change votes. Legislators were threatened in their upcoming elections. There was confusion among the Legislators since mixed signals were coming in from the grassroots of the FMA. Finally, when the final votes were cast, the bill passed both the House and the Senate by a wide margin.

Following adjournment of the Session, our staff and a few hardcore physicians had a late-night recap of the Session. Had we won, lost, or broken even? The conclusion must be that we made progress but we have not reached our final goal. Our staff is busy preparing a "glitch bill" to be introduced in the regular Session beginning April 5th to further strengthen some parts of MIRA.

All of Florida's citizens owe much to Representative Sam Bell for having the courage to take on the Trial Bar and the Speaker of the House. We all owe our FMA staff for their total commitment during the past several months leading up to the Special Session. There were countless night and weekend meetings literally all over the state. We are also indebted to our key contact physicians, Auxilians, and our county executive directors for their valuable help. To be successful in Tallahassee, we must have a unified effort.

As we gear up for the constitutional amendment petition campaign, it is important to remember that counting on each other is the key to any future success on the PLI issue.

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WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
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PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
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Mandatory Assignment Must Be Rejected

Mandatory Medicare assignment will be the next big battleground for physicians. Although legislation was successful in only two of the sixteen states where it was introduced last year, it will come back with a big splash this year in many state legislatures. This is an election year, and the opportunity has not been lost among our bleeding-heart politicians to squeeze as much favor as they can from elderly Americans. The recent increase in Medicare Part B premiums will provide additional impetus to join the bandwagon. Moreover, many states previously reluctant to embrace mandatory assignment will now take a second look after an appeals court in Massachusetts declared that state's mandatory program to be constitutional.

Forgotten in the hysteria to tie physicians to mandatory assignment is the certain loss of their freedom to charge patients for their services. In enacting Medicare in 1965, Congress made it clear that physicians can do balance billing without constraints from the government. Medicare was never intended to be an instrument towards socialized medicine, but that is exactly what mandatory assignment would lead to. Physicians will end up working as factotums for the government.

Those who have been promoting mandatory assignment, usually through the devious mechanism of tying the program to medical licensure, have been making unsavory insinuations that physicians are not being sensitive to the plight of Medicare patients. Nothing can be farther from the truth. While 40% of physicians now take assignment for all cases, the overwhelming majority accept assignment on a case-by-case basis. In Florida, where there is a large Medicare population, close to 80% of physicians accept assignment on a selective basis. Indigent Medicare patients need not fear that they will be denied access to medical care under the current system.

Imposing mandatory assignment on physicians at a time when their overhead costs are steadily rising and while their fees are frozen is bad public policy. A number of physicians, notably primary care practitioners, may elect to withdraw from Medicare for the same reasons that many of them have withdrawn from the Medicaid program. This would limit access to medical care. Those who will be forced to stay in the program because the bulk of their practices is made up of Medicare patients will have to make up for their fiscal deficits by shifting costs to non-Medicare patients, in effect creating a dual system of medical care as has happened in England. This is not a desirable situation.

When the HCFA started its participating agreements with physicians on a voluntary basis four years ago, it made it clear that it would sweeten the pie for those who would participate. It also did everything to steer Medicare patients toward participating physicians. The fact that 60% to 70% of physicians declined to participate proved that physicians cannot be bribed. The unwillingness of most patients to switch to participating physicians, on the other hand, made it clear that they are willing to pay a little extra for the right to go to the doctors of their own choice. In this context, it would be foolhardy for politicians to assume that they can ramrod a program when most physicians and patients already said they don't want any part of it.

Most physicians sympathize with the concern of the government about the escalating costs of medical care. But the government has refused to listen to them until recently. Primary care practitioners, in particular, have complained for many years about the inequities of the current reimbursement system and have pointed to a number of overpriced procedures and services as contributing to the dissatisfaction among many Medicare patients. Something has finally been done to try and address the problem. Congress created the Physician Payment Review Commission in 1986 to alter Medicare reimbursements based on relative value studies; in addition, HCFA entered into an agreement with Harvard to do a relative value study which many physicians hope will correct the current inequities of the system and eventually will be used as a basis for a new reimbursement schedule that will be palatable to everyone. The Harvard report will be out this summer.

Regardless of the current political agitation, physicians will continue to meet their ethical obligations and accept Medicare assignment on a case-by-case basis as they have been doing over the years, particularly for their indigent patients. In the offing are

a number of programs, to be sponsored by state medical societies and organizations such as the AARP, where indigent Medicare patients will receive their medical care on an assignment basis by physicians who volunteer to join these programs. In states where these have been tested, they have been quite successful and have curbed the itch of those politicians who want to impose mandatory assignment.

Easing the fiscal woes of Medicare is a complex matter that is not amenable by a draconian solution. By sweeping the rights of physicians under the rug and by creating a potential two-tier system of medical care, mandatory assignment is clearly a remedy that is far worse than the ills it is meant to cure. We must all vigorously say NO to it.

R. G. Lacsamana
Editor

High Risk Versus Low Risk — Is the Schism Fatal?

With all the recent talks and action on the liability crisis it is apparent that not all doctors in the state of Florida are united. In analyzing the situation, this is probably true in other states and spans the breadth of this country. This is a pity as the issues that divide physicians are dwarfed by other issues which unite physicians. The division, of course, has come about as high-risk physicians, represented by such specialists as OB/GYN, neurosurgeons, anesthesiologists and orthopedic surgeons, often feel that other specialists such as family practice, internal medicine, pediatrics and others do not fully understand their plight, with their malpractice premiums often exceeding $100,000 and the majority of high-risk specialists being sued at least once. The high-risk specialist has felt that he has been abandoned by the less affected internist or psychiatrist. I have perceived that the high-risk specialists have felt the FMA has not acted boldly enough and in a more militant way. They feel that while high-risk specialists are in the minority in the FMA, they are the most severely affected and their preservation and self interests are at stake. This has been even more fragmented and polarized to the geographical location of the state most affected by the liability crisis, the southeastern area.

On the other hand I have heard many of the low-risk specialists complain that when it has been time for a physician to take time off from his practice to speak to legislators or lobby for the betterment of medicine, the high-risk specialists have been reluctant to make the sacrifice of time and money to do this.

Of course, blanket indictments by anyone are usually invalid and both sides have oversimplified the issue and helped to widen the schism. There are many high-risk specialists who have lobbied tirelessly and made monetary and professional sacrifices on behalf of medicine, just as there have been many low-risk specialists who have taken strong stands to benefit the high-risk specialists.

This schism has widened over the past few months in discussions of MICA, MIRA and the just completed legislative session. Some of the high-risk specialists feel that the provisions which came out of the recently enacted malpractice bill will not substantially benefit them and that they have been sacrificed in order to achieve a bill on the liability crisis. Others have felt that some high-risk specialists are naive, recalcitrant, unrealistic, and represent a threat to any solution because of politically impossible demands.

I suppose this is an age-old problem with different interest groups, but it is a relatively new problem in medicine and has appeared over the past several decades with the advent of specialization. No longer do all doctors have the same interest on every subject. This has become a problem within the AMA as well as the FMA with the proliferation of specialty societies, each with its approach to medicine according to its particular viewpoint.

However, all segments of medicine, regardless of the specialty, have many more areas of common ground than areas of disagreement — or should have. All physicians are concerned about the ultimate care of the patient, which includes access to medical care and the obligation to see that this access will continue uninfringed. This view mandates that all physicians be as concerned about Medicare, Medicaid, care of indigent patients as well as the malpractice crisis. All physicians, high-risk and low-risk, have the obligation to invest as much time and energy as we have in the malpractice crisis.

I believe that our common beliefs and goals far outweigh the issues that tend to divide us and that our ideals for the betterment of medicine will transcend other divisive factors. The final analysis will show that our unrelenting search for the pursuit of the good of medicine will make these disagreements seem minor.

H. Frank Farmer Jr., M.D., Ph.D
New Smyrna Beach

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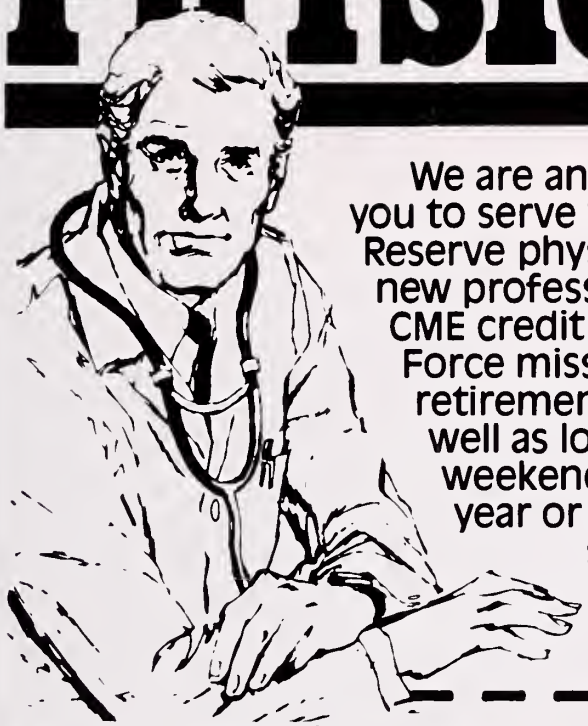

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Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

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For patients who can't or won't tolerate liquid KCl.

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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potassium chloride USP
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8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.
1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)
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Typhoid Mary 1987

The story of Typhoid Mary is known to medical and lay persons alike. To refresh your memory, Typhoid Mary was a cook in New York City at the turn of the century. At that time there occurred an epidemic of typhoid fever in New York City which affected 53 people and resulted in three deaths. After much research the cause of this typhoid epidemic was attributed to a cook named Mary Mallon who later became affectionately known as Typhoid Mary.

Once the source of the infection was discovered Mary Mallon was isolated from the food industry and from the public in order to stop the epidemic. If Typhoid Mary had lived in 1987 the scenario might have ended differently. How would the problem of Typhoid Mary be handled by our liberal and lawyer-infected society of today?

The scenario would undoubtedly proceed like this. Typhoid Mary, upon being discovered, would hire an attorney to begin proceedings to protect her civil rights. Legislation would be rammed through Congress to declare that typhoid fever is not a disease, but a disability. Since Typhoid Mary has a disability, she cannot be discriminated against. This means that her employers cannot fire her from her job. Close friends, relatives, and members of her family may not be informed of her condition unless Mary Mallon gives her permission.

As a result typhoid fever would spread across the country causing thousands and even millions of casualties. Billions of dollars will be spent on research to cure the disease. People would be advised to abstain from sex and/or wear condoms when eating in restaurants in order to protect themselves from typhoid disability. (Can't use the word typhoid disease because typhoid fever has been legislated as typhoid disability.)

In spite of the government's efforts to keep the true nature of this disease under control, the cause of the epidemic has leaked out. Now radically thinking groups want to isolate the typhoid carriers from society in order to prevent the spread of the disease. However, the government states it would be cruel and inhumane to isolate these individuals. They have rights and cannot be discriminated against because they are unfortunate enough to have such a disability.

Laws would be passed allowing children with typhoid to attend school with non-typhoid children. Parents who keep their children from school are labeled uninformed and ignorant. The American Medical Association would chastise doctors for not operating on typhoid patients.

As new cases arise each person suffering from typhoid is assigned his own attorney to assure his rights are not interfered with. Thus thousands of attorneys are employed. The government will pick up the tab for such humane services by the attorneys.

Billions are spent on doctor bills, hospital bills and attorney fees. More legislation is passed to protect the typhoid patient. The whole country is in a turmoil. As long as the civil rights of these people with typhoid disability are protected, the cost is worth it because this is America where all are treated equally no matter what the consequences.

J. N. Brouillette, M.D.
Winter Park

Editor's Note: I understand Dr. Brouilette's concerns, but physicians and society at large have ethical obligations to treat the sick, no matter what their affliction, and not to discriminate against them.

Frustrated by Blue Cross

It was a great misfortune when physicians were forced out of Blue Cross-Blue Shield management as they made it responsive to the public. The present organization is bloated with bureaucratic inefficiency. The very high premiums pay for excessive and extensive advertisements which claim benefits not available and efficiencies not present. I would expect to see on a corporate statement far too much middle management and other expenses.

I have been trying to transfer from the office group coverage (where we are being charged for major comprehensive coverage and I am getting Medicare complimentary reluctantly) for four months. One gets an answer on the 800 number about every 15-20 attempts. The local office produces a recording that says we are busy, please wait, but no one comes to the phone.

I wrote the director of sales, Mike Guyot, on November 23, 1987 and have never had the courtesy of a reply. At this stage I am tossing in the towel and looking for coverage elsewhere.

Allen Y. DeLaney, M.D.
Gainesville

Editor's Note: Dr. DeLaney is not telling us a new story. Bureaucracy and efficiency are mutually exclusive terms.

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Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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Toxic Shock Syndrome: A Problem in the Surgical Patient

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***ABSTRACT:* A case is presented of a young man with toxic shock syndrome after skin graft surgery. Postoperative toxic shock syndrome is recognized as an uncommon occurrence usually associated with persistent nonhealing surgical wounds described as benign in appearance and lacking signs of inflammation. Treatment includes supportive therapy, wound care, drainage if necessary, and antistaphylococcal antibiotics. A high index of suspicion is necessary to make the diagnosis.**

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Toxic shock syndrome was first described in 1978 by Todd et al as a distinct clinical entity.[1] They reported seven children from eight to 17 years of age who presented with high fever, headache, confusion, conjunctival hyperemia, scarlatiniform rash, subcutaneous edema, vomiting, watery diarrhea, oliguria with a tendency to acute renal failure, hepatic abnormalities, disseminated intravascular coagulation, and severe prolonged shock. All had fine desquamation of affected skin and peeling of the palms and soles during recovery. In five of the patients, *Staphylococcus aureus* was isolated from mucosal or sequestered sites but not from the blood. These organisms produced an exotoxin which was distinct from phage-group II staphylococcal exfoliatin.[1]

Also, in 1976, Faden et al reported the occurrence of a mild erythroderma in newborns associated with phage-group I staphylococcus. However, none of these neonates became particularly toxic. Todd and his associates pointed out the association of the toxic shock syndrome with phage-group I staphylococcal organisms capable of producing a toxin that could cause severe multisystem disease and profound hypotension.[1]

Since the Todd report, a wealth of information has been published concerning toxic shock syndrome. In this paper the various criteria which define the syndrome will be reviewed and the etiologic and epidemiologic factors important in understanding the syndrome will be noted. Risk factors and methods of prevention will be identified. Finally, a review of the syndrome will be presented as it occurs in the surgical patient.

Case report ● The patient is a 36-year-old white male admitted to the Plastic Surgery Service at the James A. Haley Veterans' Administration Hospital with a

several month history of noting a "mole" on his back, which had grown and changed in character. He denied any systemic symptoms and the past history was completely unremarkable. Physical examination was completely within normal limits with the exception of a pigmented 1 x 1.5 cm raised, ulcerated lesion over the right scapula. After routine preoperative preparation the patient was taken to the operating room where an excisional biopsy was performed which on frozen section was found to be a melanoma. He then underwent wide local excision and split thickness skin grafting. Postoperatively he initially did well but was noted to lose approximately 25% of the graft, secondary to inadequate immobilization. On the sixth postoperative day he was returned to the operating room and underwent regrafting. There was almost complete take of this second graft and a small portion of the wound was treated with wet-to-dry saline dressings.

The patient was temporarily discharged on the eighth postoperative day to conduct pressing personal affairs and returned after three days. He was noted to have a fever of 38.9°C and complained of nausea, vomiting and watery diarrhea. He continued to have a fever, was made NPO and begun on intravenous fluids. A marked leukocytosis with a left shift developed and he complained of diffuse myalgias. The temperature rose to 40.8°C on the third day and on the fourth day he became hypotensive with a systolic blood pressure of 80 mmHg.

He was transferred to the intensive care unit where he became tachycardic and markedly lethargic with continued diarrhea. Liver function profile revealed an elevated SGOT, bilirubin and alkaline phosphatase to twice normal. Urinalysis had five to ten white blood cells per high power field but there was no growth on urine culture. On the fifth day of the illness a diffuse macular rash, worse over the arms, hands, and feet, was noted which later coalesced and pustules developed. Cultures revealed *Staphylococcus aureus* and *Staphylococcus epidermidis*.

Throughout the whole course of illness the area of the skin graft remained clean with no evidence of wound infection. Multiple blood cultures produced negative results. By the eighth day the patient spontaneously defervesced, had a return of normal gastrointestinal tract function and was able to be transferred to the floor.

Interestingly, after the febrile episode resolved, the patient eventually lost 50-60% of the previously healed graft. The palms and soles developed near-total desquamation approximately two weeks after the episode (Figs. 1 and 2).

The patient remained afebrile and was never given antibiotic therapy. The wound was successfully regrafted and he was discharged in satisfactory condition.

The final pathology report revealed the melanoma to be Clark Level IV with a Breslow thickness of 3.0 mm. An axillary node dissection was recommended but the patient declined further surgical therapy.

Fig. 1.—Desquamated hands.

Fig. 2.—Desquamated feet.

Definition ● In February 1980, Shands et al developed a case definition of toxic shock syndrome based upon reports to the Centers for Disease Control (CDC). The important points in their definition follow:[3]

1. Fever: temperature >38.9°C.
2. Rash: diffuse macular erythroderma.
3. Desquamation of palms and soles one to two weeks after onset of illness.
4. Hypotension: systolic blood pressure <90 mmHg for adults or below fifth percentile for patients less than 16 years of age, orthostatic drop in diastolic blood pressure 15 mmHg from lying to sitting, or orthostatic syncope.

5. Multisystem involvement — three or more of the following:
   A. Gastrointestinal: vomiting or diarrhea at onset of illness.
   B. Muscular: severe myalgia or CPK level at least twice the upper limits of normal for laboratory.
   C. Mucous membrane: vaginal, oropharyngeal, or conjunctival hyperemia.
   D. Renal: BUN or creatinine at least twice the upper limit of normal for laboratory or urinary sediment with pyuria (> five white cells per high-power field) in the absence of urinary tract infection.
   E. Hepatic: total bilirubin, SGOT, or SGPT at least twice the upper limit of normal for laboratory.
   F. Hematologic: platelets < 100,000 per cubic millimeter.
   G. Central nervous system: disorientation or alterations in consciousness without focal neurologic signs when fever and hypotension are absent.
6. Negative results on the following tests, if obtained:
   A. Blood, throat, or cerebral fluid cultures.
   B. Rise in titer to Rocky Mountain spotted fever, leptospirosis, or rubeola.

With this definition, it has been possible to distinguish toxic shock syndrome from similar syndromes and to define it as a separate clinical entity.

Etiology and epidemiology ● The organism linked to toxic shock syndrome etiologically is *Staphylococcus aureus*, having been cultured from a large percentage of identifiable sites of infection. Further bacteriologic procedure has identified many of the isolates as phage-group I and a good percentage of these have been shown to produce pyrogenic exotoxin C (P.E.C.).[4] However, some of the staphylococci are phage-group III, which may be either P.E.C.-positive or negative, according to Reingold et al.[4] Most of the staphylococci are found to be resistant to penicilin or ampicillin but sensitive to beta-lactamase resistant antibiotics.

The epidemiology of the syndrome is rather complicated. CDC reported 941 confirmed cases in January 1981.[5] Eleven cases occurred in the postpartum period and the age range for patients was six to 61 years with a mean of 23 years. Males had a similar mean age, and the case fatality ratio was 7.8%.[5] Cases have been reported from at least 48 states.

It must be remembered that earlier case reports and series dealt largely with young women during or soon after the menstrual period. Davis et al demonstrated a statistically significant association between toxic shock syndrome and tampon use.[6] The exact role of the tampon in pathogenesis is not clear. They showed that though both conventional and superabsorbent tampons may produce mucosal drying and epithelial changes, microulcerations occurred more often after the use of superabsorbent tampons.[6] Also noted is a seemingly protective effect of any form of contraception. Recurrences of the syndrome have been reported but most episodes have been less intense than the initial one.

While early reports of the syndrome cited occurrences mostly among menstruating females, Reingold documented that it can be associated with almost any type of staphylococceal infection including postoperative and traumatic wounds, burns, insect bites, abscesses, mastitis, bursitis, bacteremia, and adenitis.[4]

The age, sex, and racial distribution of patients with toxic shock syndrome not associated with menstruation is different from menstruation associated.[7] The syndrome is seen in patients of all ages and races and equally often in males and females.[8]

Toxic shock syndrome in the surgical patient ● The problem of toxic shock syndrome occurring in the surgical patient is being encountered with increasing frequency — slightly less than one percent of all cases. Clinical findings are similar to those of the syndrome associated with menstruation, with fever, diarrhea, and vomiting being the earliest signs. Focal signs of a surgical wound infection before onset of symptoms are usually minimal or absent. Multiple blood cultures obtained from almost all patients are usually negative. *Staphylococcus aureus* is most often cultured from the surgical wound.

Toxic shock syndrome is usually an early postoperative complication. However, one patient had undergone reduction mammoplasty, had an ulcerated area of the surgical wound, and the syndrome developed 65 days postoperatively. Patients who have persistent, nonhealing surgical wounds late after surgery are at risk and there are minimal or no signs of infection.[9]

It is obvious that many disorders can be manifested by erythematous skin changes, hypotension, and vital organ dysfunction.[10] But, as pointed out by Fischer et al, the characteristic features of illness in patients with toxic shock syndrome are distinct from those in Rocky Mountain spotted fever, meningococcemia, leptospirosis, erytherma multiforme, drug eruptions, and systemic lupus erythematosis.[11]

Several features are similar to those in patients with toxic scarlet fever due to group A streptococci, expanded scalded skin syndrome due to group II staphylococci, and mucocutaneous lymph node syndrome or Kawasaki disease.[12] However, there is usually no difficulty recovering the organisms from the throat or other sites in patients with toxic scarlet fever. The rash in patients with toxic shock syndrome is clinically distinct from that seen in scalded skin syndrome associated with phage-group II staphylococci. Also there have been no report of strains tested

which produce exfoliatin. According to Bartlett et al,[12] there are similarities in the criteria for toxic shock syndrome and Kawasaki disease, but the rash is not papular as in Kawasaki disease patients. The definition of the syndrome must be adhered to strictly to establish the diagnosis as a distinct clinical entity.

Treatment and prevention ● Certain preventive measures against development of toxic shock syndrome have been identified. Women can almost entirely eliminate the risk associated with menstruation by not using tampons.[13] For those using tampons, the risk can be reduced by intermittent use during each menstrual period.[13]

In suspected cases of toxic shock syndrome not associated with menstruation, risk factors and methods of prevention are obviously more difficult to identify. The diagnosis should be considered in all patients with appropriate signs and symptoms regardless of age, sex, race, or menstrual status. One should be particularly suspicious in the postoperative patient with fever, rash, and other system involvement even if there are no signs of focal infection. The appearance of these signs, especially if accompanied by hypotension, dictates an immediate search for evidence of a staphylococcal infection at the operative site. These patients should have full cultures, should receive optimal fluid replacement and be begun on beta-lactamase resistant antistaphylococcal antibiotics.[4] Certainly a high index of suspicion accompanied by aggressive supportive therapeutic modalities offers the patient the best chance of recovery.

Conclusion ● Since first reported as a distinct clinical syndrome in 1978, toxic shock syndrome has attracted a great deal of attention. Initially recognized in menstruating women, it is now being found with increasing frequency not associated with menstruation. As defined by characteristic fever, rash with subsequent desquamation, hypotension, and evidence of multisystem involvement, the syndrome represents a distinct clinical entity. A toxin produced by *Staphylococcus aureus* is responsible for the symptoms in these patients.

The syndrome is being recognized with increasing frequency in the postsurgical patient, usually with no clinical findings of infection at the surgical site. The findings of fever, diarrhea, erythroderma and hypotension demand an immediate search for evidence of a staphylococcal infection at the operative site and the institution of appropriate supportive therapy. A high index of suspicion offers the best chance for correct diagnosis, proper therapy, and complete recovery.

References

1. Todd, J.; Fishart, M., et al: Toxic Shock Syndrome Associated with Phage-Group I Staphylococci, Lancet 2:1116, 1978.
2. Faden, H.S., et al: Nursery Outbreak of Scalded Skin Syndrome, Am. J. Dis. Child. 130:265, 1976.
3. Shands, K.N., et al: Toxic Shock Syndrome in Menstruating Women, N. Engl. J. Med. 303:1435, 1980.
4. Reingold, A.L., et al: Toxic Shock Syndrome not Associated with Menstruation, Lancet 1:1, 1982.
5. Centers for Disease Control: Toxic Shock Syndrome — United States 1970-1980, Morbid. Mortal. Weekly Report 30:25, 1981.
6. Davis, J.P., et al: Toxic Shock Syndrome — Epidemiologic Features, Recurrence, Risk Factors, and Prevention, N. Engl. J. Med. 303:1429, 1980.
7. Reingold, A.L.: Toxic Shock in the United States of America: Epidemiology, Postgrad. Med. 61:23-24, 1985.
8. Reingold, A.L.; Hargrett, N.T.; Dan, B.B.; Shands, K.N.; Strickland, B.Y., and Broome, C.V.: Nonmenstrual Toxic Shock Syndrome: Review of 130 Cases, Ann. Int. Med. 96:871-874, 1982.
9. Morrison, V.A. and Oldfield III, E.C.: Postoperative Toxic Shock Syndrome, Arch. Surg. 118:791-794, 1983.
10. Fischer, R.F., et al: Toxic Shock Syndrome in Menstruating Women, Ann. Int. Med. 94:156, 1981.
11. Centers for Disease Control: Toxic Shock Syndrome — Utah, Morbid. Mortal. Weekly Report, 29:495, 1980.
12. Bartlett, P., et al: Toxic Shock Syndrome Associated with Surgical Wound Infections, JAMA 247:1448, 1982.
13. Centers for Disease Control: Follow-up on Toxic Shock Syndrome, Morbid. Mortal. Weekly Report 29:441, 1980.

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Treatment of Obsessive-Compulsive Disorder

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ABSTRACT:* Epidemiologic studies suggest that obsessive-compulsive disorder (OCD) may affect 2% of the general population. The life impact of OCD can be serious, often threatening interpersonal relationships and employment. Behavioral therapy can be an effective treatment. Recent studies suggest biological factors in the etiology. Controlled evidence demonstrates that pharmacologic therapy can also be helpful. Clomipramine (Anafranil), an investigational tricyclic antidepressant, has emerged as the pharmacologic treatment of choice. Placebo-controlled double-blind trials reveal an improvement rate of 70-80%. Other promising drugs are currently being studied. With increasing media attention toward this disorder, more patients will be consulting their primary care physician or mental health professional for guidance and referral.

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Carmen used to love nursing. She now "cleans" her "contaminated" hands 60 to 100 times a day after work. Alan's work takes him on the road most of the day. He crosses an intersection while the light is yellow. "I might have caused an accident!" After a couple of blocks he must turn back to "check." A few miles later, distracted by the radio, he briefly runs off the road. He wonders whether he might have dislodged a pebble into the roadway that may cause an accident. He turns around to check again. Marge is a "hoarder." She saves all her empty food containers. Her kitchen cabinets are full of smelly empty milk cartons and used cans of dog food. Now her bathroom is becoming cluttered with the same garbage.

Ann's disorder was atypical in that during therapy its origin was revealed. When she was 24, her mother was hospitalized. On her way to visit her she had a horrible thought, "I wish that my mother was dead!" She panicked. "How could I ever think such a thing?" During the next few weeks her life was miserable. The thought would not leave her mind, "I wish that my mother was dead!" After pondering the pros and cons of her dilemma for the millionth time, the "answer" came. "If I touch the wall plate of a light switch the thought *will* go away!" Miraculously it worked but she was trapped. Ann learned that every time the thought would come she could touch the plastic plate and it was gone. Soon, in the same sudden way the thought was born, she had forgotten its origin, but the compulsion remained. Now several times a day she had the urge to touch the wall plate and to turn the light switches on and off.

Ken was principally a "cleaner" but also a part-time "checker and hoarder." He cleaned everything, even if it was already clean. After a turbulent marriage and the embarrassment of becoming impotent, he had separated from his wife. Ken lived alone, had no

friends, and after work he would return to his apartment to clean. Recognizing his abnormal behavior he sought psychiatric treatment which led to negative experiences with antipsychotic drugs.

Currently Ken is being prescribed an investigational drug. His doctor asked him to return all of the unused medication after each visit. At first he would not return the pills. "I just forgot. I will remember and bring them all back next time." Weeks later he returned them all and "confessed." "Doctor, those bottles were dirty because they had been at my place. I had to clean each pill with a cotton swab." Ken is better now, but he continues to "clean," keeping everything immaculate.

Overview of obsessive-compulsive disorder ● It is estimated that 2% of the population suffers from obsessive-compulsive disorder (OCD).[1] This would make it a common illness. However, the physician must differentiate OCD from obsessive-compulsive traits as there may not be an association. Those with obsessive-compulsive traits are extremely neat, orderly, thoughtful and conservative. They may also be rigid, stubborn, and possess little creativity. Some of these common personality features may be valued in some settings.

There are psychiatric patients with obsessive-compulsive symptoms whose primary illness is not OCD. The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III) defines Obsessive-Compulsive Disorder as either obsessions or compulsions that are a significant source of distress or interfere with social or role functioning. The symptoms must also not be due to another mental disorder. Obsessive-compulsive symptoms are frequently encountered in patients with phobic disorders. However, the principal developmental conflict as well as some of the common clinical characteristics of the phobic patient are different from those with OCD. Other psychiatric patients that commonly suffer from obsessive-compulsive symptoms include those with depression and psychotic disorders including Tourette's syndrome. Those patients with delusional depression who develop nihilistic ideas, depersonalization, and paranoid ideas, may also have severe obsessive-compulsive symptoms. Patients with obvious psychotic disorders also suffer from these symptoms. The principal difference between those with OCD and others with schizophrenia does not lie upon the complexity and bizarreness of their ideas and rituals, but on the observation that those with OCD have insight into their illness and are desperately longing to maintain social contacts.

Many adults in their 20s and 30s seeking therapy for OCD will admit to distinct episodes of symptoms prior to adolescence. During their childhood and adolescence they cleverly concealed their illness. Some investigators have observed that OCD victims often have above average intelligence and are at least of a middle-class background. In most cases (Ann, the light switch "checker," is an exception) no distinct origin or precipitating event for their disorder can be found. A helpful diagnostic feature of patients with OCD is their exaggerated concern in their behavior for the welfare and safety of others. Ken (the pill polisher) as well as Alan (the roadway circumnavigator) present typical examples. Unfortunately this altruistic concern is not always present, but its presence helps differentiate the phobic from the obsessive-compulsive.

The repetitive, unwanted, irrational and incomprehensible impulses and rituals usually bring the patients to treatment. They may report years of multiple psychotherapeutic interventions and aggressive pharmacotherapy without success. In many cases the benzodiazepines have been helpful in at least alleviating the accompanying severe anxiety. These patients will often resist and sabotage any insight-oriented psychotherapeutic attempt. Because of their resistance and its limited therapeutic value, behaviorists often ignore the basic "free association" process that includes discovery and insight enhancing strategies and opt for direct symptom definition and a goal directed approach. However, short-term dynamic psychotherapy has been found useful in mildly obsessive-compulsive and phobic patients when symptoms are relatively acute in onset.[2]

Treatment of obsessive-compulsive disorder ●

A. Psychotherapeutic management

Behavioral therapy has emerged as the preferred psychotherapeutic treatment in the management of OCD.[3] The behaviorist repetitively exposes the patient to the offending stimuli while firmly preventing the performance of the accompanying ritual. Due to the patient's characterological rigidity, plus the anxiety relieving quality of the ritual, therapy often becomes a "tug-of-war."[4] It is often impossible for the therapist to be present to prevent the behavior from occurring, thus less direct strategies must be employed. Often the relief of symptoms is partial and transient, until a new cycle begins with perhaps different rituals.

B. Biological factors

There is increasing evidence that OCD may be associated with biological factors. Monozygotic twins studies indicate a genetic predisposition for OCD.[5] Recently published results of positron emission tomography (PET) scans performed on patients with OCD reveal metabolic imbalances in specific frontal lobe structures, rich in serontonergic neurons.[6] After pharmacologic therapy and subsequent response, the uniformity of the metabolic rate in these areas improved. The neurotransmitter serotonin may play an important role in the modulation of repetitive behavior and may be the common denominator in the etiology of OCD.[7,8] Further evidence to support the "serotonergic theory" lies in observations of

pharmacologic response. Those compounds that activate specific groups of serotonin receptors seem to worsen the disorder while drugs that reduce serotonin activity are effective in its treatment. Clomipramine (Anafranil), an antidepressant structurally of the tricyclic group, has received the most worldwide attention in management of OCD.[9,10]

C. Pharmacologic treatment with clomipramine

Some investigators believe that the pharmacokinetics of clomipramine may account for some of its behavioral altering qualities. Clomipramine has a longer elimination half-life than other tricyclics such as imipramine (Tofranil and others), amitriptyline (Elavil and others) and desipramine (Norpramin and others). If this observation alone could account for clomipramine's effectiveness in OCD, then other antidepressants would produce comparable results as long as similar serum concentrations could be achieved. However, published double-blind studies do not support this view.[11,12] Instead, they point toward a unique activity of clomipramine based upon its complex pharmacodynamic interactions.

Clomipramine's principal pharmacologic effect in vitro is to inhibit serotonin re-uptake into presynaptic neurons, perhaps to a greater degree than other tricyclics. This factor probably accounts for its demonstrated efficacy in OCD. Although over 2,000 patients have received clomipramine for the treatment of OCD in the U.S. during investigational trials, the drug is unlikely to be approved in this country in the near future. Clomipramine is marketed in other nations as an antidepressant. It first became available in Europe in the 1960s and since then has been approved in most other countries. It is also marketed in some nations specifically for the treatment of OCD. At present clomipramine is prescribed to carefully selected patients who meet strict symptomatic and safety criteria at the University of Miami School of Medicine Department of Psychiatry, Division of Psychopharmacology, in association with the manufacturer, Ciba-Geigy.

Controlled studies have confirmed that the therapeutic dose of clomipramine in the treatment of OCD is similar to its antidepressant dose.[10,12] Comparable to our own experience, most trials report a 70-80% improvement in adults with doses in the range of 100-200 mg per day. As with other tricyclics, this dose must be gradually achieved as some patients present a marked sensitivity. There is also a response lag with clomipramine. Published studies report that optimal improvement does not usually occur until several weeks of treatment at a therapeutic dose. Those obsessive-compulsive patients who can be expected to optimally respond to clomipramine manifest primarily compulsive behavior, irrespective of accompanying obsessions or impulses. Patients with only obsessions seem poor candidates. Clomipramine has also been prescribed to children and adolescents with OCD,[7,13] although the total number of children treated has been small and a few studies have been controlled.

The adverse effects of clomipramine are similar to those of the other tricyclics. Patients will frequently report anticholinergic reactions, most commonly dry mouth, blurred vision and constipation. These are similar in frequency and severity to those encountered with doxepin (Sinequan, Adapin). Clomipramine is a sedative tricyclic and many patients will report drowsiness. The sedative effect of most tricyclics can be minimized by prescribing most or all of the medication at night. At the University of Miami our group has opted to use clomipramine and other sedating tricyclics almost always in a single nighttime dose, with a decisive reduction in complaints of daytime sedation and fatigue and an improvement in overall compliance. There is some indication that clomipramine may be more epileptogenic than other tricyclics. Although the incidence of spontaneous seizures is low, its higher frequency with clomipramine may represent an artifact of improved investigational reporting. Additionally, sexual dysfunction in both sexes and increased sweating may be more frequently encountered with clomipramine.

D. Other pharmacologic alternatives

There are reports of other useful pharmacologic treatments for OCD. The new antidepressant trazodone (Desyrel) has been found effective, perhaps because of its selective activity for serotonin receptors.[6] However, there are no large controlled clinical trials yet available to confirm the efficacy of trazodone in OCD. Of greater interest are some positive reports with the investigational antidepressants fluoxetine and fluvoxamine.

Fluoxetine is a bicyclic antidepressant developed in the U.S. by Lilly Research Laboratories. Unlike trazodone, it is a potent serotonin uptake inhibitor. Fluoxetine has received preliminary approval by the FDA. Its marketing as an antidepressant under the trade name Prozac seems imminent. It is different, both chemically and pharmacologically, from the tricyclics and other available antidepressants.[14] Its effectiveness is similar to currently available drugs but it is less likely to cause certain side effects. Fluoxetine lacks the annoying anticholinergic action of most antidepressants. It does not appear to significantly affect heart function, does not cause drowsiness, and has not been associated with increased appetite and weight gain. The primary side effect at therapeutic doses is nausea. In our experience since 1981, the drug seems to be extremely well tolerated. At our site some patients sensitive to the side effects of clomipramine have responded more favorably to fluoxetine.

Two trials have been published evaluating fluoxetine in the treatment of OCD.[15,16] One was single-blind, the other was open. Both trials treated a small number of patients. The doses were similar to those prescribed for depression. Both trials showed an improvement with fluoxetine therapy regarding the amount of time patients spent obsessing and ritualizing.

Role of primary care physician in management of OCD ● The news media has paid increasing attention to this disorder. Although elegant descriptions of the symptomatology date back to 1903,[17] there is no doubt that many patients have been misdiagnosed. Treatment for those seriously afflicted, until recently, had been generally unsuccessful. Many patients impaired by these symptoms have elected to conceal their illness. As we improve our understanding of the pathophysiology of these and similar disorders, many forms of biological therapies will be scientifically evaluated. Untreated patients considering "coming out of the closet" are likely to first consult with their primary care physician for advice, guidance and referral. It is imperative for the medical community to be aware of OCD and its symptoms, and to be able to discuss treatability of the illness.

At present those who suffer from OCD can be best managed by the mental health professional. Psychotherapy, especially current behavioral approaches, is helpful. Pharmacotherapy remains investigational and limited in the United States. It is the primary care physician's responsibility to appropriately refer these patients. The mental health practitioner can best evaluate the features of the disorder, arrive at a differential diagnosis, and decide the most adequate therapeutic approach.

References

1. Robins, L.N.; Helzer, Y.E.; Weissman, M.M., et al: Lifetime Prevalence of Specific Psychiatric Disorders in Three Sites, Arch. Gen. Psychiatry 41:949-967, 1984.
2. Sifneos, P.E.: Short-Term Dynamic Psychotherapy of Phobic and Mildly Obsessive-Compulsive Patients, Am. J. Psychother. 34:314-322, 1985.
3. Marks, I.M.: Review of Behavioral Psychotherapy: I. Obsessive-Compulsive Disorders, Am. J. Psychiatry 138:584-592, 1981.
4. Salzman, L.: Psychotherapeutic Management of Obsessive-Compulsive Patients, Am. J. Psychother. 34:323-330, 1985.
5. Hoaken, P.C.S. and Schnurr, R.: Genetic Factors in Obsessive-Compulsive Neurosis? Rare Case of Discordant Monozygotic Twins, Can. J. Psychiatry 25:167-172, 1980.
6. Baxter, L.R.; Phelps, M.E.; Mazziotta, J.C., et al: Local Cerebral Glucose Metabolic Rates in Obsessive-Compulsive Disorder, Arch. Gen. Psychiatry 44:211-218, 1987.
7. Flament, M.F.; Rapoport, J.L.; Murphy, D.L., et al: Biochemical Changes During Clomipramine Treatment of Childhood Obsessive-Compulsive Disorder, Arch. Gen. Psychiatry 44:219-225, 1987.
8. Thoren, P.; Asberg, M.; Bertilsson, L., et al: Clomipramine Treatment of Obsessive-Compulsive Disorder: II. Biochemical Aspects, Arch. Gen. Psychiatry 37:1289-1294, 1980.
9. Ananth, J.; Solyom, L.; Bryntwick, S., et al: Chlorimipramine Therapy for Obsessive-Compulsive Neurosis, Am. J. Psychiatry 136:700-701, 1979.
10. Thoren, P.; Asberg, M.; Cronholm, B., et al: Clomipramine Treatment of Obsessive-Compulsive Disorder, Arch, Gen. Psychiatry 37:1281-1285, 1980.
11. Anath, J.; Pecknold, J.C.; Van Den Steen, N., et al: Double-Blind Comparative Study of Clomipramine and Amitriptyline in Obsessive Neurosis, Prog. Neuropsychopharmacol Biol Psychiatry 5:257-262, 1981.
12. Insel, T.R.; Murphy, D.L.; Cohen, R.M., et al: Obsessive-Compulsive Disorder: Double-Blind Trial of Clomipramine and Clorgyline, Arch. Gen. Psychiatry 40:605-612, 1983.
13. Flament, M.F.; Rapoport, J.L.; Berg, C.B., et al: Clomipramine Treatment of Childhood Obsessive-Compulsive Disorder: Double-Blind Controlled Study, Arch. Gen. Psychiatry 42:977-983, 1985.
14. Sommi, R.W.; Crismon, M.L., and Bowden, C.L.: Fluoxetine: Serotonin-Specific, Second-Generation Antidepressant, Pharmacotherapy 7:1-15, 1987.
15. Turner, S.M.; Jacob, R.G.; Beidel, D.C., et al: Fluoxetine Treatment of Obsessive-Compulsive Disorder, J. Clin. Psychopharmacol. 5:207-212, 1985.
16. Fontaine, R. and Chouinard, G.: Antiobsessive Effect of Fluoxetine (ltr.), Am. J. Psychiatry 142:989, 1985.
17. Janet, P.: Les Obsessions et la Psychasthenie, Paris, Alcan. 1903, vol. 1.

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XX Male: Case Report with Overview

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***ABSTRACT:** A 20 year-old patient is presented with a male phenotype and a female (46 XX) karyotype. Clinical findings resembled Klinefelter's syndrome in many respects. The hormonal, cytogenetic studies and histology of testes were consistent with the diagnosis. The theories and hypothesis regarding genesis of this sex chromosome abnormality is reviewed and discussed.*

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An XX chromosomal constitution in a phenotypic male was first reported by de la Chapelle et al in 1964.[1] Since then this condition has received wider recognition. The paucity of cases in the literature reflects the low incidence of this condition. The incidence has been estimated as one XX male among 20,000 to 30,000 newborn males.[2] The XX male appears as an exception to the hypothesis that a Y chromosome [3] is essential for development of the testes. Different theories have been proposed to explain male differentiation in the apparent absence of a Y chromosome; however, as yet there is no unifying hypothesis that explains all the facts known about the XX male.

This article presents a discussion of an XX male, emphasizes pathologic findings in the testicular biopsy, and reviews different hypotheses postulated to explain the pathogensis of this disorder.

Case Report ● A 20 year-old black man was referred to University Hospital of Jacksonville with a three-year history of breast enlargement. Puberty had begun at age 14 with normal changes in external genitalia and voice but with scant growth of facial hair. He had experienced gradual enlargement of breasts since age 18. The patient was not married. He complained of inability to maintain an erection.

On examination the patient was found to be thin, short, and normal in appearance and intelligence, height as 162.5 cm and weight 55 kg. He showed bilateral gynecomastia. The penis and scrotum were normal, the testes were small and soft, and pubic hair had a female distribution.

Semen analysis showed no sperm. Serum hormone levels were: follicle-stimulating hormone 49 milli IU/ml (normal 5-25), lutenizing hormone 58 milli IU/ml (normal 6-30), testosterone 532

nanograms/100 ml (normal 300-1000). The right testis measured 2 x 2 x 1, and the left testis 2½ x 2 x 1 cm. Bilateral testicular biopsy was performed. Microscopically, more than half the seminiferous tubules were completely hyanilized and atrophic and many of those remaining showed varying degrees of atrophy with thickening of basement membrane. None showed evidence of spermatogenesis. A total absence of germ cells was noted, only Sertoli cells were present. An increased number of Leydig cells were seen within the interstitium. (Figs. 1,2).

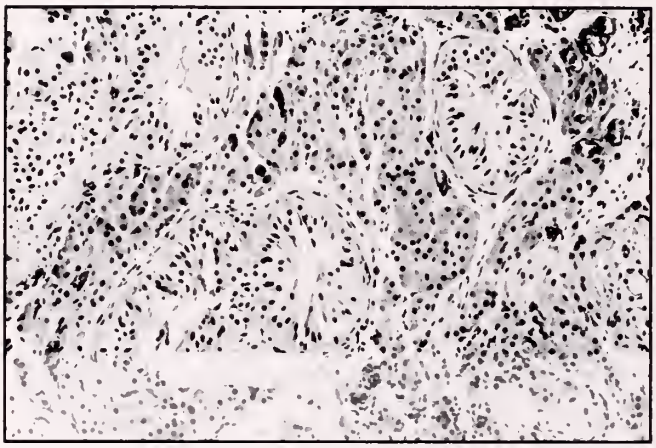

Fig. 1.—Testicular biopsy showing advanced atrophy of seminiferous tubules with thickening of the basement membrane and increased number of Leydig cells within the interstitium.

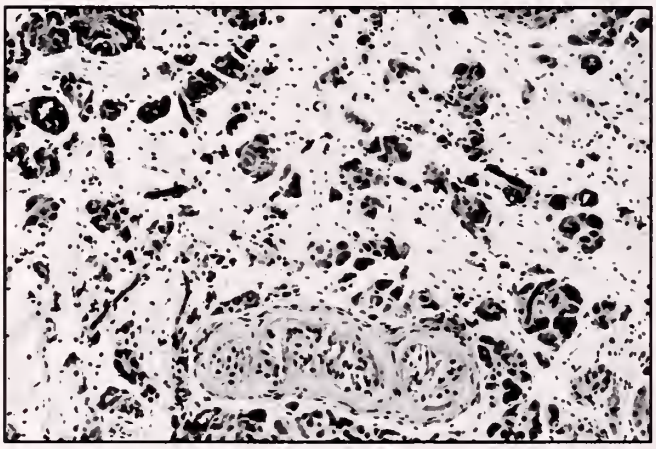

Fig. 2.—Higher view of the testicular biopsy demonstrating absence of spermatogenesis, prominent Sertoli cells, and hyperplasia of Leydig cells.

Buccal smear repeatedly showed positive Barr bodies in more than 60% of epithelial cells examined. Cytogenetic studies using standard trypsin banding procedure on peripheral lymphocytes and the testes showed 46XX karyotype (Fig. 3). The fluorescent technique described by Caspersson et al,[4] which uses quinacrine hydrochloride for identifying Y chromosome, was performed. The results were negative in buccal smears, cultured lymphocytes, and testicular tissue.

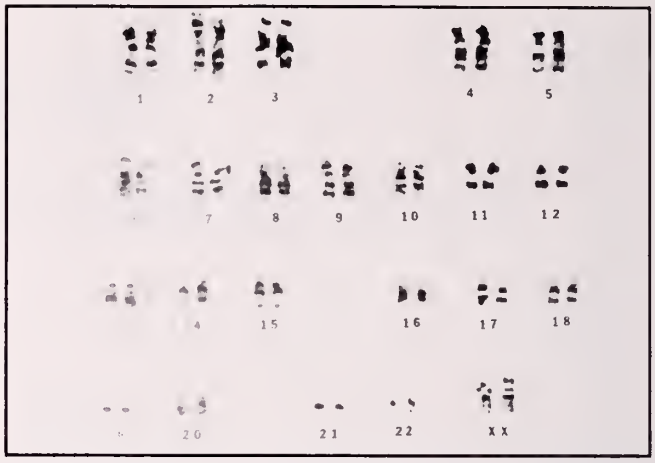

Fig. 3.—Trypsin banding of a 46XX male.

Discussion ● According to de la Chapelle, typical XX males exhibit a male phenotype, male psychosexual identifiation, normal intelligence, short stature, male body proportions and male testicular, ductal and external sexual differentiation.[5] The incidence of gynecomastia as well a pubic hair and body hair distribution is similar to that in Klinefelter's syndrome.[5] However, normal male hair pattern can occur. The penis and scrotum are usually normal. Testicular size is almost invariably decreased.[6] Histologic features of the testes closely resemble those found in patients with Klinefelter's syndrome, i.e., absence of spermatogenesis, hyalinization and obliteration of seminiferous tubules, peritubular fibrosis and hyperplasis of Leydig cells.[7] Semen analysis frequently shows azoospermia.[8] Low fructose content in seminal fluid indicates the insufficiency of Leydig cells.[9]

Testosterone has been found to be low or within lower limits of normal.[10] The majority of XX males have increased levels of pituitary gonadotropins, a finding consistent with the hypothesis that the deficiency of Leydig cells necessary to produce testosterone is directly responsible for the increase in the production of pituitary gonadotropins.[11]

Despite the similarities between the XX male and Klinefelter's syndrome, the dermatoglyphics of XX males do not demonstrate a consistent pattern or similarity with the features commonly found in Klinefelter's syndrome. On the contrary, a certain tendency in the dermatoglyphics deviations towards Turner's syndrome was present.[9]

Although the precise etiology and pathogenesis of this condition have not been clearly elucidated, several hypotheses explain its possible mode of determination. The gene theory speculates that male determination is the function of an automomal gene. In

support of this hypothesis, Kadsan and his associates reported a family in which XX maleness appeared to be transmitted in a Mendelian fashion.[12]

The Mosaicism theory assumes that at least some XX males result from the triggering of the male differentiation process by a line of cells containing a Y chromosome. Later, this cell line becomes very scarce or totally eliminated, thus undetectable or difficult to detect by current cytogenetic methods.[6] Direct evidence to support this hypothesis has been provided by demonstrating low grade mosaicism in six cases reported by de la Chapelle and associates in 1972 and by other reports.[5,6,8,10,13]

In 1966 Ferguson-Smith postulated a translocation of the segment of the Y chromosome containing the male determining genes to the X chromosome.[7] The author proposed that an interchange could take place during the first meiotic division of the spermatocyte when the X and Y chromosomes are closely associated. Ferguson-Smith stated that, since individuals with isochromosomes of the long arm of the Y chromosome who lack the short arm of this chromosome have a female phenotype, the male determining genes are probably located on the short arm of the Y chromosome. Because of the small size of this segment, a translocation of short arm material onto the X chromosome might easily pass undetected and cause the testicular differentiation seen in XX males. This hypothesis of reciprocal X-Y interchange is supported by the atypical inheritance pattern of the X-linked Xg blood group demonstrated in nine XX males and one true XX hermaphrodite whose phenotype was xg(ā) although their fathers were xg(a). This interchange could result from a reciprocal translocation that would transfer the xg^a allele to the Y chromosome and the male-determining gene to the X chromosome.[14] Cytologic evidence of the interchange hypothesis has been provided by Modan and Walker[15] and by Wachtel et al.[13] They described XX males whose karotypes showed minute additional material at the tip of the short arm of one of the X chromosomes. The authors postulated that, if the morphologic difference between the two X chromosomes was considered to be beyond the limits of normal variation, the extra material probably derived from the short arm of the Y chromosome with which the X chromosome pairs during meiosis.

In 1955 Eichwald and Silmser found that female mice sometimes reject skin grafts from males of the same inbred strain, i.e., cells from males express a cell surface component known as the H-Y antigen, whereas cells from females do not.[16] Later this observation served as the basis for demonstrating a correlation between the H-Y antigen and the Y chromosome. Wachtel and associates speculated that in man the H-Y antigen is determined by a Y-linked gene since cells from males with two Y chromosome produce more H-Y antigen than cells from normal XY males.[17] Therefore, demonstration of a positive immunologic assay for H-Y antigen in four XX males and three XX true hermaphrodites suggested the presence of Y chromosomal material.[13] Based on this observation, Wachtel and his associates concluded in 1976 that the occurrence of Y derived male determining genes in a translocation or mosaic cell line appears to be the most likely explanation for male differentiation in "XX" individuals.[13]

Later, as the technique of DNA hybridization progressed, a number of human Y-specific single copy probes were isolated.[18] In 1984, using several of these Y-specific probes, Guellaen et al demonstrated the presence of Y-chromosomal material in the genome of some 46XX human males.[19] These XX males carried only a fraction of the human Y chromosome. In their three positive cases reported, presence of inclusive overlapping chromosomal fragments has been detected, implying a genetic heterogeneity of the patients.[19] Thus, it seems that the etiology of XX males is probably heterogenous. The underlying mechanisms may include errors of X-chromosome inactivation, mutations in autosomal or X chromosomal genes and X-Y interchange.[20]

Our case showed the classic findings of the XX male syndrome. The immunologic assay for H-Y antigen and DNA probing, if available, could have probably helped in further characterization of this patient's problem.

References

1. de la Chapelle, A.; Hotling, H.; Niemr, M., et al: XX Sex chromosome in a Human Male: First Case, Acta Med. Scand. 412 (Suppl.):25-38; 1964.
2. de la Chapelle, A.: Etiology of Maleness in XX Men, Human. Genet. 58:105-116, 1981.
3. Ohno, S.: Simplicity of Mammalian Regulatory Systems Inferred by Single Gene Determination of Sec Phenotypes, Nature 234:134-137, 1971.
4. Caspersson, T.; Zech, L.; Johansson, C., et al: Identification of Human Chromosomes of DNA-binding Fluorescing Agents, Chromosoma 30:215-277, 1970.
5. de la Chapelle, A.: Nature and Origin of Males with XX Sex Chromosome, Am. J. Hum. Genet. 24:71-105, 1972.
6. de la Chapelle, A.; Simila, S.; Lanning, M., et al: Two Further Males with Female Karyotypes, Human Genetik 11:286-294, 1971.
7. Ferguson-Smith, M.A.: X-Y Chromosomal Interchange in Etiology of True Hermaphroditism and of XX Klinefelter's Syndrome, Lancet 2:475-476, 1966.
8. Dosik, H; Wachtel, S.; Khan, F., et al: Y Chromosomal Genes in Phenotypic Male With a 46 XX Karyotype, JAMA 29, 2505-2508, 1976.
9. Sperling, K. and Koden, Hirsch: Casustic Contribution to XX Male Problem, Humangenetic 17:145-154, 1973.
10. Palutke, W.; Chen, Y., and Chen, H.: Presence of Brightly Flourescent Material in Testes of XX Males, Med. Gen. 10:170-198, 1973.
11. Dequrt, J.; Michard, J.P.; Louchardt, J., et al: L'ordhidodystrophie Polygonosomique (Syndrome dit de Klinefelter), Sem. Hop. Paris 38:1249-1265, 1962.
12. Kadsan, R.; Nankin, H.R.; Traen, P., et al: Paternal Transmission of Males in XX Human Beings, N. Engl. J. Med 288:539-545, 1973.
13. Wachtel, S.; Koo, G.; Breg, W., et al: Serologic Detection of Y-linked ¼gene in XX Males and XX True Hermorphrodites, N. Engl. J. Med. 295:750-754.
14. ¼ferguson-Smith, M.; Johnston, A., and Weinberg, A.: Chromosome Complement in True Hermaphroditism, Lancet 2:126-128, 1960.
15. Madan, K., and Walker, S.: Possible Evidence for XP+ in XX Male, Lancet 1:1223, 1974
16. Eichwald, E.J., and Silmser, C.R.: Skin, Transplant Bulletin 2:148-149, 1955.
17. Wachtel, S.S.; Koo, G.C.; Breg, W.R., et al: Expression of H-Y Antigen in Human Males with Two Y Chromosomes, N. Engl. J. Med. 292:1070-1072, 1975.
18. Bishop, C.E.; Guellaen, F.; Geldwerth, D., et al: Single Copy DNA Sequence Specifics for Human Y Chromosomes, Nature 303:831-832, 1983.
19. Guellaen, G.; Casanova, M.; Bishop, C., et al: Human XX Males with Y Single - Copy DNA Fragments, Nature 307:172-173, 1984.
20. de la Chappel, A.; Tipett, P.A.; Wellerstrand, G., et al: Genetic Evidence of X-Y Interchange in Human XX Male, Nature 307:170-171,1984.

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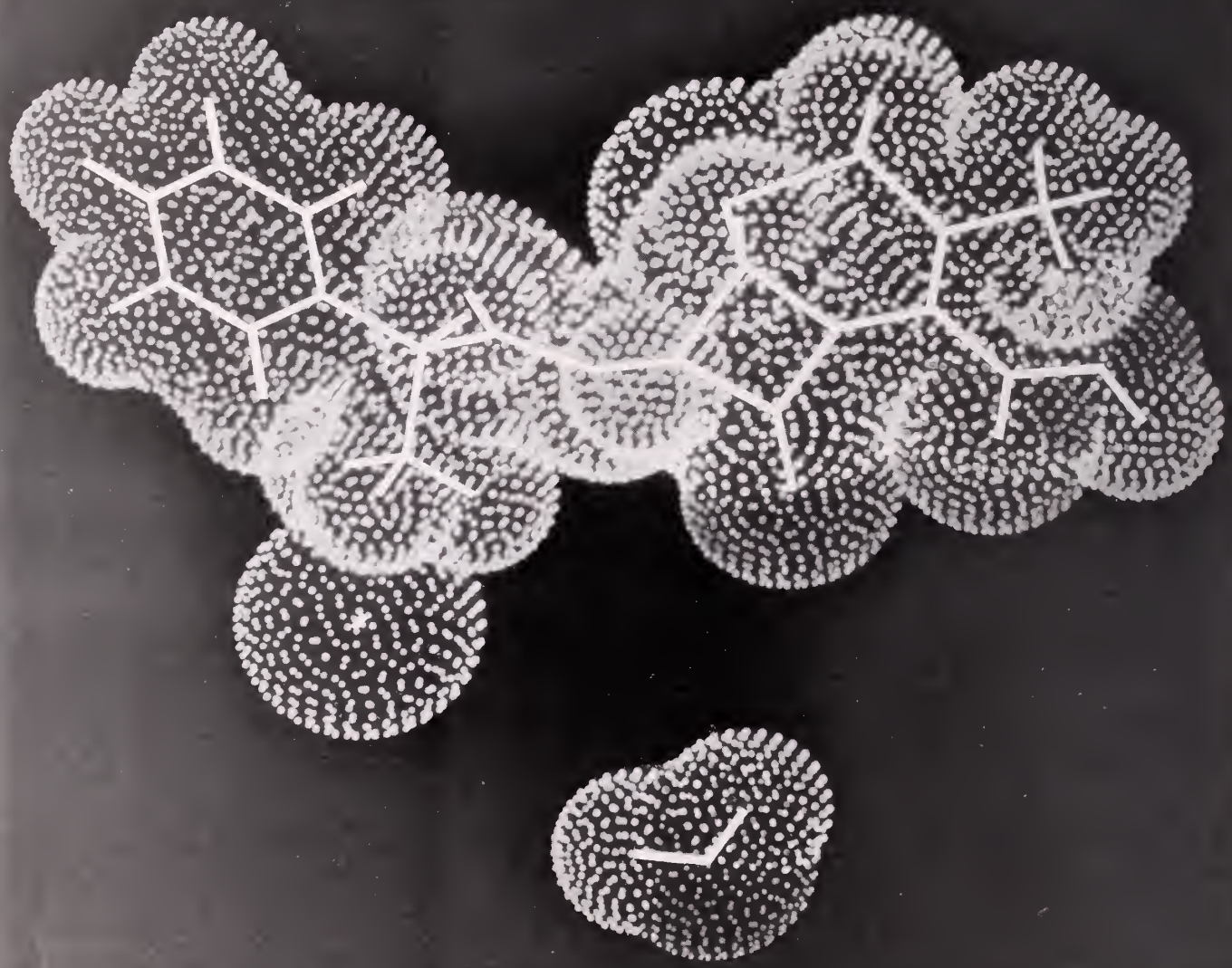

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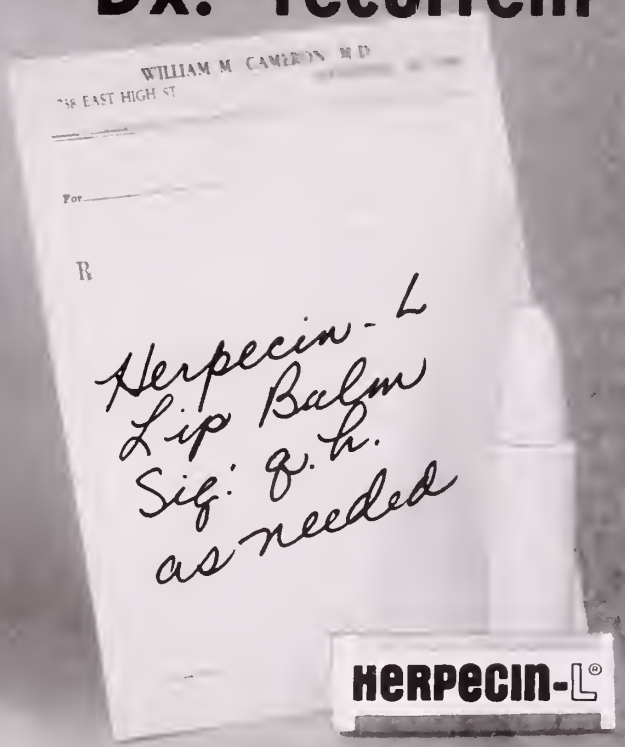

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Back-to-Basics Survival Tips for Medicine

Dale C. Havre, M.D.

The image of medicine is tarnished. The majority of our patients claim to like us as individual physicians but they do not seem to think much of our profession. Their increasing displeasure is being manifested in a number of undesirable ways. Two of the more serious are a relentless erosion of our freedom to practice without third-party interference and the alarming willingness of patients to sue us. The house of medicine is steadily losing friends despite the fact that most of us care deeply about our patients and our profession.

Why is our image suffering? The reasons are multiple and complex but one factor stands out: a decline in the quality of relationships. Since people are what medicine is all about, perhaps it would be worthwhile to examine the details of a few of these human interactions. From my perspective as a recently retired physician, having been in active clinical practice for 22 years, I realize that many kinds of relationships constitute the total practice of medicine. In the spirit of the "Back to Basics" theme chosen by Dr. James G. White as the watchword of his 1987-88 FMA presidential year, I would like to share some of my thoughts about these vital relationships.

The Author
DALE C. HAVRE, M.D.
Dr. Havre is an ophthalmologist who retired after 22 years of practice. He now spends most of his time doing professional writing, including a weekly column for his hometown newspaper. With this issue, he also starts a new monthly column, "Eye-to-Eye," for The Journal.

Relationships with Patients

1. *Give patients their money's worth.* We all like to receive value for our money. Two of the most frequently expressed complaints about doctors are that they "won't take the time to listen" and are "too busy to explain things to you." If medicine is to survive commercialization and remain a noble profession, I suggest that we all make time to listen to our patients and to talk with them. This signifies to the patient that we truly care about him or her. If we don't have time for these essentials, then we are probably scheduling too many patients. If listening to patients' complaints annoys us, or if we don't like to teach, then we are probably in the wrong profession.

2. *Respect patients' time.* Most of us dislike having to wait very long for an event to take place, particularly if it might be unpleasant and expensive, such as a visit to the doctor's office. In order to keep waiting time in our offices to a minimum, we should schedule patients realistically. If we schedule more patients than we are capable of seeing in a given amount of time, several things invariably happen. First, if we are giving each patient enough time to care for him or her properly, then we are going to fall behind. Patients who are fidgeting in the waiting room will express their anxiety or anger to the staff. The staff, in turn, will get upset and the whole office will begin to emit an aura of unhealthy tension. Conversely, if we are overbooked but running on time, then our patients are probably being shortchanged in the attention department; and that will eventually lead to nothing but problems.

Another way to reduce waiting time for our patients is to start office hours on time. If being very late is unavoidable, the secretary should call patients who have not yet arrived and offer them a later time or an appointment on another day. Patients who are stewing in the waiting room should be given an explanation for the delay and provided with an opportunity to reschedule their appointments.

A doctor should apologize to a patient who has been waiting an inordinate length of time (more than 30 minutes) and demonstrate his sincerity by offering the patient an appropriate fee reduction. A cursory, "Sorry you've been waiting," seems pretty hollow after reading old magazines for two hours. A patient once said to me, "You know, doctor, my time is just as important as yours. Every minute is precious at any age." He was right, of course. His life was being measured in the same units as mine.

3. *Be the patients' advocate in things medical.* We should try to help our patients deal with hospitals, insurance companies and government agencies. Let them know we are on their side and willing to assist them in any reasonable way. If you have had a recent encounter with the medical bureaucracy for an illness in your own family, then you know how frustrating and confusing the system can be.

We should select the physicians to whom we refer our patients with great care. We should be able to tell a patient honestly that the doctor we are recommending is one we would go to if we had a similar problem.

Keeping up with advances in our chosen fields is a must, legally and ethically. We owe it to our patients to stay current in our medical knowledge and skills. Patients should feel confident that their doctor is "on top of it" in the medical arena. Continuing education also helps us recognize questionable medical practices and deal with them authoritatively.

Inspiring the trust of our patients is not nearly so important as deserving it. Good medical judgment is a sine qua non for staying out of trouble. It comes not just with study but with experience and a genuine desire to possess it. Good judgment transcends self interest. A patient should always be able to know that the doctor is truly his friend in all things medical.

4. *Know your patient as a person.* That disease we are trying to diagnose or treat is just one part of a very complex human being. Acknowledging and respecting the whole person make us much better physicians. The patient's physical problems may never get better if his or her emotional needs go unanswered. We should be aware, too, that the patient's environment may completely neutralize the most sophisticated medical therapy.

Relationships with Colleagues

5. *Respect colleagues' time.* How many times has your secretary paged you, while you were busy with a patient, to answer Dr. So-and-So's telephone call and when you picked up the phone his secretary said, "Please hold for Dr. So-and-So"? I personally consider this to be one of the most egregious of medical etiquette blunders. It is always proper, and respectful, to be waiting on the line when your colleague answers.

Similarly, when we ask another physician to see a patient in consultation, it is always better to speak to him personally rather than through a ward clerk or a little slip of paper that contains such an edifying message as "Consult in room 422A. Left eye." If the consultant knows why we want him to see the patient and how urgent the request is, then he can plan his time most efficiently. He will know, for example, whether to allow time for dilating drops to work and if he will need to bring an indirect ophthalmoscope from the office. Simple courtesy can save our fellow physicians a lot of time.

6. *Keep colleagues informed about patients in common.* If we have seen a patient at the request of another physician, we should promptly let him know what we found and what we think. A timely call or a short note will always be appreciated. A longer, detailed letter can follow if needed.

If we are about to prescribe a medication for a patient, and we are not sure whether it is compatible with what another physician has prescribed for that patient, give Dr. Other a call. He will appreciate the concern, and so will the patient. The ensuing discussion about the patient's problems might be helpful to everyone concerned.

7. *Don't knock a colleague's work in front of a patient.* If we are tempted to make some disparaging remark about another doctor's surgical handiwork or clinical acumen, particularly within earshot of a patient, we should forget it. Nothing is gained and much may be lost in the lawsuit that so frequently results from such injudicious comments. If our ego needs a boost, we should find other ways. We are all susceptible to the bite of the "humble bug" because every doctor has patients who do not reflect his or her usual good work.

8. *Be compassionate toward a troubled colleague.* Physicians are definitely not immune to physical or emotional problems. The incidence of alcoholism, drug abuse, depression, divorce and suicide among physicians is surprisingly high. Job burnout is probably more common than most of us would like to admit. Perhaps this says something about the stresses that are accepted as a part of our profession. Perhaps, too, it reflects a reluctance on the part of doctors to express their problems to their colleagues. A fear of rejection or ridicule by one's peers seems to persist in this supposedly enlightened age.

Many state medical societies have established outstanding programs for impaired physicians. This is a good start toward recognizing the physician as a vulnerable human being. Perhaps if we offered a more sympathetic and sensitive ear to our colleagues on a day-to-day basis, we could prevent the more serious problems from developing. A little kindness can work wonders for doctors, too.

Relationships with Office Staff

9. *Respect your staff members' time.* We sometimes forget that our secretaries and assistants have a life outside the office. They do, of course, and it is not fair for us to assume that they really enjoy staying in the office after normal hours. We might not

hear them complain but that does not mean that they wouldn't like to. Trying to start and finish office hours on time is one way we can show more consideration for our staff's personal lives.

Having office members perform chores for us or our families can be another source of unvoiced displeasure. When asked if they would mind picking up our kids from dance class on Friday evenings, they might agree only because they don't want us to question their loyalty. Baby sitting, dog sitting, personal shopping, and bartending at our gala socials at home are similar areas for possible abuse of our staff's time and self-image. Unless we can be certain that they enjoy these activities, we should try to avoid making such requests. Any hidden resentment will eventually manifest itself as undesirable employee behavior.

10. *Explain to the staff what we expect from them.* Each member of our staff should be given a written job description when he or she is first hired. We should not make employees play guessing games about what we want them to do. An office policy manual is really the best way to inform the employees about our way of running the office. Whatever it is we want should be put in writing. Anything that improves the quality and the clarity of our communications with the staff is well worth the effort.

11. *Reward the staff for a job well done.* Everyone likes to be appreciated. If the staff are doing an outstanding job, we should tell them we are pleased. We can give them medals or framed certificates of appreciation, but we shouldn't forget to give them a raise in pay. Regular salary reviews are very important. If someone truly deserves a raise, he or she should get it. Salary ceilings should be ignored if we have a smooth running, productive office. Extra days of paid vacation are also coveted rewards.

12. *Try to keep employees' jobs interesting.* Learning the intricacies of a new piece of equipment will challenge some employees, but even small changes in the office routine can be refreshing to everyone. Whenever possible, for example, we should let employees alternate their duties so that they do not get bored with the repetitive tasks. Offer to send the more highly motivated assistants to appropriate weekend seminars or enroll them in available correspondence courses. It makes the job more appealing, and everyone benefits from increased knowledge and enthusiasm.

Relationships with Family

13. *Respect your family's time.* All through our medical training we are taught to put our patient's needs first. Meals are delayed or missed, social functions are ruined, sleep is interrupted, personal relationships are strained — all in the name of the patient's welfare. We and our families are obliged to endure a significant measure of such sacrifice, but it can easily be overdone. If we are routinely absent when our families need us, we are too busy for our own good. It would be wise to reassess our goals and take some corrective action. Relegating family life to the back burner is unwise and could be risky. Time passes too quickly to count on making it up to the family later. Later could be too late.

14. *Don't overdo it with material possessions.* It's nice to have money and it's fun to spend it, too. There is, however, a certain propriety that should be respected, both for the image of medicine and for the welfare of the family. With the seemingly relentless trend towards commercialization of medicine, our patients are beginning to wonder where our hearts really lie. Are we interested in them because we want to help them, or are we more interested in how they can help us pay for a collection of big-ticket items? If a patient cannot trust his own doctor, whom can he trust? Our families should also be sensitive to the negative effects that perceived ostentation can have, not only on themselves but also on the image of the medical profession in general. Overindulgence is never a pretty sight.

15. *Invest wisely for the family.* It takes a lot of discipline to save money for events that will not occur for many years. College funds, retirement funds, and provision for the family in the event of death are examples that apply to many of us. The first temptation is to procrastinate. That inevitably leads to some pretty serious cash flow problems at the time the event occurs. If, for example, college expenses are added to current obligations, we may find ourselves having to work harder than is good for us, or we may be tempted to compromise our standards of medical practice in order to generate more income.

Another temptation is to "go for the gold" and make up for lost time or inadequate planning by investing in financial adventures that promise high yields. We all know that big risks are usually (if not always) associated with such investments. If we definitely want the money to be there when we need it, we should opt for more conservative investments. It may not be so exciting that way but the family will thank you for it.

16. *Respect the identity of family members.* A successful, respected physician can sometimes inadvertently overshadow the personal identity of his spouse or children. They might find it tiresome, if not downright frustrating, to always be referred to as Dr. So-and-So's wife (or husband) or child. It is hard to go wrong if we encourage family members to develop their own unique talents and if we enjoy the individuality of each one.

Relationships with Self

17. *Recognize our limitations.* If we all could learn to recognize our weaknesses and could live with them without feeling inadequate, I think the world would be a better place to be a patient in. We shouldn't be afraid to say, "I don't know," to a patient. If we have

tried our best, and we still don't know what's going on inside that body, we should admit to the patient that we are stumped. More often than not, he will respect your honesty and will trust you more than ever. Getting a second opinion in these circumstances is usually more of a blessing than it is an admission of defeat.

18. *Indispensable we're not.* No matter how wonderful we and others think we are, don't believe for a minute that we cannot be replaced. If any one of us should die tomorrow, our patients might do some wailing and wondering about how they are going to get along without us. Before long, though, our former patients would be nicely absorbed by the remaining medical community.

I don't wish to sound morbid about this subject but rather hope to put it into perspective. A physician can be more forgiving of himself and of others if he views his life and his practice from a position of reasonable humility. He will also be more appealing to his family and friends.

19. *Listen when your body talks.* Many physicians ignore in themselves the same symptoms they find alarming in their patients. Although this is not prudent, it is certainly understandable. There is never a convenient time to get sick. If we are having worrisome symptoms, we should seek the wise counsel of our colleagues. I have yet to meet a doctor who was not honored to help a fellow physician.

20. *Know, yourself, when it is time to quit.* Sooner or later we all will begin to lose that sharp mental and/or physical edge that makes us good physicians. We will find it increasingly difficult to muster the enthusiasm and endurance of yesteryear. If these symptoms are relatively mild, we can compensate for them by changing our practice routines. But if there is any question about the safety of our continuing to practice, then the good judgment that has served us so well in the past should prevail at this time of transition in our lives.

Those are my 20 back-to-basics pearls, culled from 22 years of experience in practice. I cannot claim that even one of them is an original jewel but I can vouch for their proven value. Strengthening our relationships with patients, colleagues, office staff, family and ourselves can only improve the image of medicine and make our own lives more rewarding.

● Dr. Havre, 1816 Kimberly Lane, Inverness 32652.

The Demise of the Independent Doctor: A Self-Fulfilling Prophecy?

Pepi Granat, M.D.

***ABSTRACT:* Most physicians wish to preserve their freedom and autonomy not only for themselves but in order to deliver the best medical care. Some physicians together with businesspeople/bureaucrats are engaged in subtle attempts to eliminate the relatively-independent and autonomous practice of medicine. Yet when physicians join together to preserve their individual freedom, they could be accused of antitrust activities. A whole profession may be losing its nobility and mobility on the altar of the dollar. "Managed" health care in whatever form (government or corporate) can exist beside autonomous and independent medical care without overwhelming the system, but only if physicians beware the self-fulfilling prophecy that independent medicine is dead, by actively and innovatively rejecting the false and misleading "hype" which surrounds them. Medical organizations nationwide, instead of following trends, should be taking the lead to preserve freedom for doctors and patients.**

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Among the "junk" mail were two slick brochures, the design imaginative, paper unique, printing impressive. One touted the organizer-M.D.'s expertise at teaching us to work within HMOs, IPAs, PPOs. The other proposed to tell us what medicine will be like in the year 2000. One's slogan was "Don't miss this opportunity to learn about the future of medicine;" the other, "Changing relationships between hospitals and physicians."

We, ourselves, become led and misled by the hype.

Some of our own physicians-turned-businessmen/bureaucrats plus genuine businesspeople/bureaucrats are engaged in subtle attempts to band together to eliminate the relatively-independent and autonomous practice of medicine; yet when we join together (though apart) to preserve our individual freedom, we could be accused of antitrust activities!

Many of us form a silent majority who know that it is not only our self-interest as physicians which is at stake but the dismantling of the fine medical system we have known.

Freedom and autonomy: uses and abuses ● Most of us who practice medicine in the real world wish to preserve freedom and autonomy of individual physicians. We have the old-fashioned belief that this is genuinely the best way to give medical care to people.

Multiple problems involve not just physical illnesses but other factors in peoples' lives; their physician becomes their true advocate, who can move freely within whatever systems are involved with getting them what they need and making them well.

Most physicians used to feel this way. Now many say freedom is dead (a self-fulfilling prophecy?).

Sadly, a few, but very few, physicians abuse their freedom and also abuse the third-party payer systems, especially Medicare, which physicians opposed originally knowing it would lead to cost overruns. These physicians over-charge and over-utilize, wishing to be free so that "no one will look over their

shoulder." So it happens that politics makes strange bedfellows: those who welcome scrutiny may ally with those who have something to hide.

Costs and causes ● Data show that costs of our entire "medical system" are due mostly to hospitals and other medical business charges including health insurance and professional liability insurance. Physicians' over-utilization and over-charging must be a fraction of the problem since only 19% to 21% of the entire medical costs "pie" represents all physician charges. A hue and cry from the public goes out that the entire system is now unaffordable. Therefore we must ensnare all doctors to work within some sort of controlled and "managed" health care scheme. This throws the baby (maintenance of freedom and autonomy for physicians for the benefit of patients) out with the bath water (the morass of cost overruns and over-utilizations, which weren't attributable to most doctors in the first place).

And if over-supply of physicians is a problem, and some of us are struggling, how can more middlemen (adminstrators) splitting the medical dollar be of help?

There are segments of the population who, for whatever reason, are willing to compromise their medical care. They and their employees wish to pay less. They can get fairly adequate medical care through various organizational schemes.

This is the HMO concept and we need not oppose this as one of the alternatives in medicine.

Having an HMO as an alternative is far different from having the concept become the only, albeit less desirable, means of delivery of medical care.

Conflicts, capture and control ● The doctors who work in the HMO, IPA, and even PPO framework can never be true patient advocates because they do not have true freedom themselves. There are conflicts of interest constantly hamstringing them right down to the loss of their very jobs and/or their patient base. Patients need to know this.

Follow the logic of an HMO organizer. 1. Independent doctors really are better for free people. 2. When doctors are independent some may charge too much. 3. People cannot afford to pay too much. 4. Although most overpricing has not been due to physicians in the first place, let's entice the doctors by offering to "help" them. 5. We will take their patients. 6. We will give the patients back to the doctors through well paid middlemen (some of whom are doctors, themselves). Then we will have control of every aspect of access to medical care and a share of every dollar spent.

The people will say they are paying less; they won't know they are getting less. The doctors will say they are still getting "fee for service." But once the patient population has been "captured" and enrolled in a large organization which sets a fee schedule and doles out money and medical care according to its own decisions, the doctor who for a while was satisfied will be completely within the "managed" health care sphere. The doctor (and the patient) will then be unable to move in either direction. They will have lost their power, control and cash flow.

Same lorry — different driver ● This is the case with socialized medical schemes as well as with corporate medical schemes and it does not matter who controls it; doctors, businessmen, or bureaucrats. The individual physician and patient will still be in a "managed" health care scheme. In the words of an African song: Same lorry (truck) — different driver.

Territorial imperative ● Abraham Lincoln, in 1859, was running for president.

The debate was: Should slavery, though it was entrenched in the South, be allowed to spread into the Federal Territories?

This is what Abraham Lincoln had to say, " . . . wrong as we think slavery is, we can yet afford to let it alone where it is because that much is due to the necessity arising from its actual presence in the nation; but can we, while our votes will prevent it, allow it to spread into the National Territories, and to overrun us here in these free states? If our sense of duty forbids this, then let us stand by our duty, fearlessly and effectively."

He reasoned: " . . . their thinking it right and our thinking it wrong, is the precise fact upon which depends the whole controversy. Thinking it right, as they do, they are not to blame for desiring its full recognition, as being right; but, thinking it wrong, as we do, can we yield to them? Can we cast our votes to their view, and against our own?" He finished, "Let us have faith that right makes might, and in that faith let us, to the end, dare to do our duty as we understand it."

Just as we should acknowledge that HMOs, IPAs and other schemes for managed health care may have their place and their advocates, we should fight for the concept of not letting them spread out of the territory which they now occupy into the larger territory of independent medicine, itself, and certainly not by our own hand through our own medical organizations.

"Our duty as we understand it" ● We need to put out a call to organized and unorganized medicine all over this country, even though we know that certain county and state medical organizations have legitimized the concept by forming their own IPAs, HMOs and PPOs. We need to put out a call to doctors who have not joined with organized medicine partly because they have felt that organized medicine has done and can do nothing for them. Perhaps if they realize the firm stand that we will take for the independent doctor they will close ranks with us. This is not to say that doctors who work within HMOs and IPAs should be disenfranchised. Organized medicine should stand for individual physicians wherever they

are, within whatever system they practice. But the concept that HMOs and IPAs exist should not imply that they will sweep this country and it won't, unless we allow it to happen. There is still time left.

By limiting individual autonomy we will become enslaved and ensnared in managed health care which ultimately will not benefit our individual and free patients.

Finding solutions ● Well, you say, what are the alternatives? There are many; we need only to find them. That is where we should be putting our efforts. Many organizations are cropping up around the country with the sole aim of preserving independent medical practice.

The most important corollary will be that we — if we choose to remain independent doctors — will have to act responsibly and never allow ourselves to succumb to the temptation of over-utilization and excessive pricing in the field of medicine. Physicians in technical specialties and for-profit ventures in which it is possible to accumulate great wealth by "practicing medicine" should rethink their positions very carefully. A whole profession may be losing its nobility and mobility on the altar of the dollar.

Plans in perspective ● For a young doctor coming out of training, an HMO, like military service, is an opportunity to work, earn money, and get his/her feet wet in medicine. He/she will soon realize as I did working in various "jobs" in medicine, (city health departments, maternal and child health clinics, college health services and other forms of managed health care) that in no case is he/she allowed to be a true advocate of his/her patients.

He will yearn for the autonomy that he knows he requires in order to do right by his patients.

He will then go into practice, perhaps on a shoe string. He will spend a few years not making much money because his practice is young, and then he will make a reasonable living and support his family not with great wealth but with adequacy.

Some people may elect to stay in managed health care schemes. This is fine but there should be the other option, of being an independent doctor among free people.

The media and the message ● We should be looking for innovative means of delivering this and similar messages to our own doctors and to the public. We should be involved in lowering total medical costs for patients. We should not be involved in plans for setting up subgroups within our medical organizations which stand to gain economically from investing in IPAs and HMOs and whose adminstrators will, of course, be paid for their efforts and will form another wedge between the doctor and the patient.

"Doctor-controlled and doctor-owned" has very little meaning in this context. No matter who controls it, you the physician will not have a voice and the steamroller will roll over you (and your patients). I believe that there are a lot of us out there — perhaps a silent majority — who agree.

Speak up and speak out ● Why must we acquiesce so easily? Why must we believe the advertisements that we hear on TV and radio when we know differently? In this age of media madness, why must we be part of a self-fulfilling prophecy? Why must we join every plan for fear of being left out, instead of remaining resolutely free of such encumbrances?

Perhaps we simply have not managed our own media approach to ourselves properly. Perhaps we don't have the collective confidence and will.

I think we do. Think it over. Are you part of that silent majority? If so, speak up and speak out — now before it's too late.

I think we should beware of self-fulfilling prophecies. We may be down but we're not out. But if we lie down and let the HMO, IPA and other "managed" schemes roll over us, we will get what we deserve because we haven't fought the fight and the face of medicine will be changed forever.

● Dr. Granat, 7800 Red Road, Suite 202, South Miami 33143.

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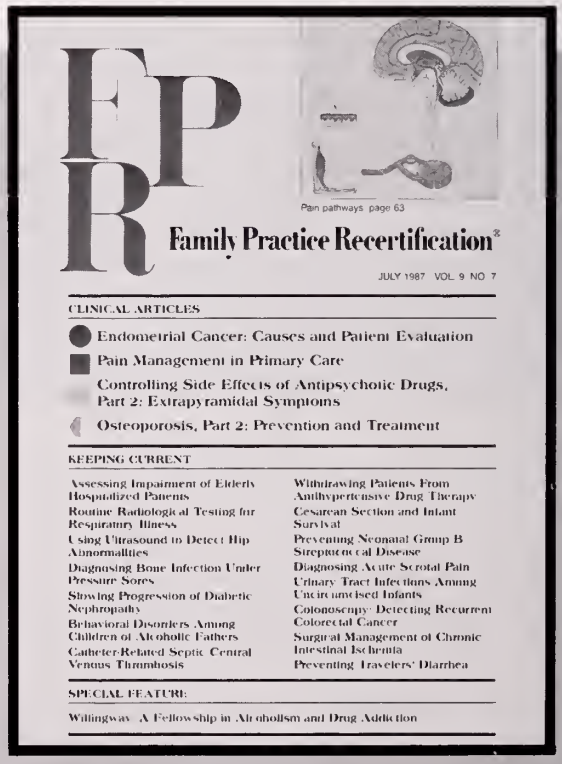
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Is the Gatekeeper Concept Legitimate or Another Mirage on the Cost Containment Trip?

A significant medical trend of the 1980s has been the resurrection to prominence of the family physician. Just two decades ago, some observers were predicting that the general practitioner and family practitioner would become an extinct and fossilized chunk of bric-a-brac on the mantlepiece of medical history. One result of the resurgence in numbers of family physicians has been their recruitment as "gatekeepers" to the medical care system. As such these doctors are supposed to control access into the system. The current wisdom has been that percolating patients through such filters will rigorously reduce the use of medical specialists and hospitalization, thereby reducing the cost of medical care. Nearly all HMOs and PPOs employ some form of the "gatekeeper" — indicating an *a priori* assumption that the use of the gatekeeper does, indeed, save money. Unfortunately, a closer inspection demonstrates that the gatekeeper system may not be as cost effective as assumed.

The gatekeeper is usually the family doctor who controls patient use of the medical care system. This person provides the care for most of the patient's common and uncomplicated illnesses and decides upon the appropriateness and timeliness of specialist referral, of hospital admission, and of use of specialized diagnostic tests such as x-rays, CAT scans, mammography, etc. Traditionally this has been the manner by which the primary care doctor (which term includes family practitioners, internists, and pediatricians) has always behaved. However in recent years, the sophisticated public that is insured outside the PPO-HMO system, frequently seeks out specialty care and high-tech diagnostic tests themselves without consulting the primary care physician. Such independent reconnoitering of the medical care landscape by the patient is disallowed in a gatekeeper system. The patient must pay for any elective services received that were not previously approved by the gatekeeper doctor.

The underlying assumption of the economic feasibility of the gatekeeper system is that primary care doctors use fewer medical care resources than do specialists. Superficially, this is true. Data exist to show that general and family practitioners use fewer diagnostic tests and spend less time with a patient with a certain condition than do internists or specialists. For instance, pulmonologists use more sophisticated testing and treatment procedures in managing the patients they see with chronic obstructive pulmonary disease (COPD) than do family practitioners[1,2] treating COPD. Unfortunately these studies do not correct for the severity of the patients' illness that the specialist sees versus the severity of the disease process in patients maintained by the family practitioners. Nor do these studies correct or evaluate quality of care. It has been shown that specialists, practicing within the bailiwick of their expertise, deliver a higher grade of care than do either generalists or other specialists who are practicing in a problem area foreign to their realm of expertise.[3,4] Specialists also charge higher fees and use more hospitalization than do family practitioners; thus they are deemed to be more expensive. Whether this specialty care translates into long term economic benefits or detriments to either the medical care system or to the financial well-being of the patient has not been considered in the currently available studies.

Only one study has examined the effectiveness of the primary care gatekeeper as a cost-containment mechanism.[5] The United Healthcare Corporation, organized by the Safeco Life Insurance Company, initiated the gatekeeper concept during the 1970s in an independent practice association (IPA) HMO that was the largest in the United States at the time. The

primary care gatekeeper physician was paid on a capitation basis. A 10% holdback of reimbursement was enforced if the plan experienced a deficit. Specialists and hospitals were reimbursed on a fee-for-service basis. During the first year of its operation (1978) the plan was a success. Thereafter, it showed a loss in its operations. From 1978 through 1981 the plan suffered a 56% increase in its annual dollar costs per enrollee. Referral care increased 64% and hospital care 72%. The imposition of the gatekeeper did not succeed in containing health care costs and the plan was terminated.

Collectivisation of efforts, such as in agriculture or manufacturing, has never been economically efficient in any socialist country in which it has been enforced. Furthermore, a capitated gatekeeper system has been in place in Great Britain for over 40 years; that system has not reduced hospitalization or specialty referral.[9]

The reasons for the failure of the Safeco experiment were multiple. The authors of the study felt that the financial restrictions imposed on physicians were not rigorous enough. Physicians did not change their practice behavior in terms of hospitalization and in terms of referrals to specialists. The primary care doctors were penalized if the whole plan lost money. The authors of the Safeco study failed to acknowledge that a capitation system provides no incentive to give continuous care to the more severely ill person or for the patient with chronic disease. The primary care physician incurs greater overhead and loses income by caring for such individuals and will tend to refer such individuals to the specialist.

Since 1980 the HMO-PPO industry has layered a tier of graver financial penalties on the primary care gatekeepers who fail to constrict their referral to specialists and rates of hospitalization. Fee holdbacks in the range of 10-30%, liens on future earnings, decreased payment for services in ensuing years, or discharge from plan participation are the financial whips used to enforce arbitrary, administratively dictated budgetary goals on the primary care providers.[6] Despite the attempts to impose greater financial risk on the providers, containment of health care costs by HMOs and PPOs is failing. Over 75% of HMOs showed a loss last year.

The futility of imposing greater financial risks on the provider was exemplified superbly by the failure of the Sunshine Health plan, an IPA that had existed in Volusia County until its financial demise in the summer of 1987.[7] In an attempt to slow the plan's losses the physician holdback was increased from 10% to 20%. The plan's losses tripled in the next six months. Financial restraints imposed on physicians may not be successful cost containment vehicles. Burkett has reported that physicians adapt to such restraints with time and that the initial cost containment changes that appear in the physician's practice style become diluted within about two years of membership in an HMO plan.[8]

Economic researchers are confused by this failure of "risk sharing" imposed on the physician provider to reduce specialty referrals, hospitalizations, and medical costs in general. Their confusion could be dissipated by a discussion with any physician. The HMO recruits the physician by demanding a fee discount or by granting the doctor a ludicrous capitation fee, and then strangles the doctor's income further by establishing a holdback system that subtracts an additional 10-30% from the physician's earnings, In the majority of HMO and PPO organizations, the holdback is enforced on all physician if the plan fails to meet its budgetary goals. Thus the physician is responsible, not only for his own behavior, but for the collective behavior of hundreds of other doctors that he does not know and for the administrative and accounting miscarriages of the plan's management. The doctor nets very little real income from such arrangements and has no incentive to assure the plan's financial success. Why should economists be surprised at this outcome? Collectivisation of efforts, such as in agriculture or manufacturing, has never been economically efficient in any socialist country in which it has been enforced. Furthermore, a capitated gatekeeper system has been in place in Great Britain for over 40 years; that system has not reduced hospitalization or specialty referral.[9]

Recent editorials have questioned the ethics of reimbursing physicians for denial of patient care.[6,10] The physician is expected, and usually does, operate in a manner which he judges to be optimal for the patient. However, the enforcement of financial penalties for providing optimal care may induce physicians to severely limit the services they render to HMO patients so that they can maintain solvency. The IMC experience in southern Florida is the most extravagant example of abusive denial of patient care in order to satisfy the budgetary demands of an HMO. Congress has responded to this threat by prohibiting payment of services to physicians who operate in a manner that entices them to reduce the level and quality of services.[11]

The fundamental assumption of medical economists who espouse the gatekeeper system as a means of reducing health care costs is that specialty care is expensive and that specialty referral necessarily results in higher cost to the health care system. This assumption has not, to my examination of the literature, ever been tested. Contrarily, the ascent of the specialty care system in the United States has been associated with an increase in the quality of care and in a reduction in the cost of illness to the entirety of American society (when one considers not just the

cost of the medical care provided but also the cost of illness in terms of the financial productivity of the ill person)[12] Furthermore the knowledge and skills of the specialist may reduce the total cost of care of certain conditions. I will give two examples.

Dyspepsia is a very common complaint in the primary care environment. The usual response of the gatekeeper doctor is to assume that such patients have peptic ulcer disease and to treat such individuals with antacids and H2 blockers. The majority of patients with dyspepsia have non-ulcer dyspepsia or other conditions that will not respond to such treatment. The patient's symptoms may not disappear and the patient will again approach the family doctor who changes to or adds another medicine. Since the patient is not too sickly in appearance the doctor sends the patient away with a multimonth prescription. The patient then orders his or her prescriptions from the HMO in three to six month batches. The costs of these prescriptions, which will not adequately treat the patient's undiagnosed condition, usually runs $500-$800 per year — an amount that is wasted for that individual patient. A gastroenterological referral, which costs far less than a year's medication, may be able to rapidly define the condition and manipulate dietary and other changes in the patient lifestyle that may resolve or ameliorate the symptoms and save the medical care system hundreds of dollars in unnecessary prescription costs.

The fundamental assumption . . . is that specialty care is expensive and that specialty referral necessarily results in higher cost to the health care system.

Another example can be elicited from the rheumatologic field. Marketing studies have revealed that the primary care doctor uses aspirin as the drug of choice in managing most types of arthritis because aspirin tablets are cheap and as effective as alternative forms of therapy — such as the nonsalicylated, nonsteroidal antiinflammatory drugs (NSNSAIDs). This practice would appear to be cost effective. However, if one compares the total cost of treating a group of arthritic patients with aspirin versus the cost of treating with the NSNSAIDs, one learns that aspirin management is 2.5 times more expensive. The reason is that aspirin causes up to five times more gastrointestinal bleeding and causes signficantly more gastritis and dyspepsia than do the recently formulated NSNSAIDs. These aspirin adverse effects greatly increase the necessity of using H2 blockers and antacids and strikingly increase the frequency of hospitalization for GI catastrophes caused by the aspirin therapy. Thus aspirin therapy, administered by the family doctor for the care of the arthritic patient, is alluringly seductive as a cost effective means of management. An economically scholarly thrust beneath the superficialities of the assumption refutes its validity.

The gatekeeper system, after ten years of use in the United States in a variety of formats, has no data to support its legitimacy as an effective, health care cost-containment tool. Its use has been an attractive postulate. Unfortunately, some of life's most noisome paradoxes are that the simple is really complex; that the undersurface of the superficially attractive is hideously unappealing; and that the economic pathway that appears most obviously correct invariably leads to financial ruin. The history of the gatekeeper system has been tainted by each of these paradoxes.

Sick people will continue to become ill and will need, want and deserve medical care. Doctors will provide it. Physicians over the centuries have been overwhelmingly honest and have practiced their profession with integrity and patient-centered care. Interlopers from government and businesses have not yet been able to contain the cost of medical care in this or in any other affluent society despite their multifarious tinkerings with the system. Perhaps it is time to enlist doctors as allies, rather than as victims, in the attempts to properly contain health care costs.

References

1. Mendenhall R.C.; Moynihan, C.J., and Radecki, S.E.: The Relative Complexity of Primary Care Provided by Medical Specialists. Medical Care 22:987-1001, 1984.
2. Greenwald, H.P.; Peterson, M.L.; Garrison, L.P., et al: Interspecialty Variation in Office-Based Care. Medical Care 22:14-29, 1984.
3. Rhee, S.O.; Luke, R.D.; Lyons, T.F.; et al: Domain of Practice and the Quality of Physician Performance. Medical Care 19:14-23, 1981.
4. Payne, B.C.; Lyons, T.F., and Neuhaus, E.: Relationships of Physician Characteristics to Performance Quality and Improvement. Health Sciences Research 19:307-332, 1984
5. Moore, S.H.; Martin, D.P., and Richardson, W.C.: Does the Primary Care Gatekeeper Control the Costs of Health Care? N Engl. J. Med. 309:1400-1404, 1983.
6. Hillman, A.: Financial Incentives for Physicians in HMOs. Is There a Conflict of Interest? N. Engl. J. Med. 317:1745-1748, 1987.
7. Caldwell, J.R. and Duke Jr., H.L.: Terminal Agony and Final Moments of Physician-Owned HMO: Postmortem, JFMA 74:785-788, 1987.
8. Burkett, G.L.: Variations in Physician Utilization Patterns in a Capitation Payment IPA-HMO. Medical Care 20:1128-1139, 1982.
9. Glazer, W.: Paying the Doctor. Baltimore, Johns Hopkins Press, 1975.
10. Woodward, R.S. and Warren-Boulton, F.: Considering the Effects of Financial Incentives and Professional Ethics on 'Appropriate' Medical Care. J. Health Econ. 3:223-237, 1984
11. Iglehart, J.K : Second Thoughts About HMOs for Medicare Patients. N. Engl. J. Med. 316:1487-1492, 1987.
12. Caldwell, J.R.: Cost of Illness: A Fresh Perspective on the Non-Crisis in Health Care Costs, JFMA 74:527-529, 1987.
13. Koldny, A.L. and Klipper, A.: Final Report on Cost of Treating Arthritic Disease: Comparison Between Salicylates and Non-Salicylates, Non-Sterolial Anti-Inflammatory Drugs. Seminars in Arthritis and Rheumatism 14(3)(1):20-24, 1985.

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INFORMATION FOR AUTHORS

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Titles should be short, specific, clear and amenable to indexing. Titles should not exceed 80 characters, including punctuation.

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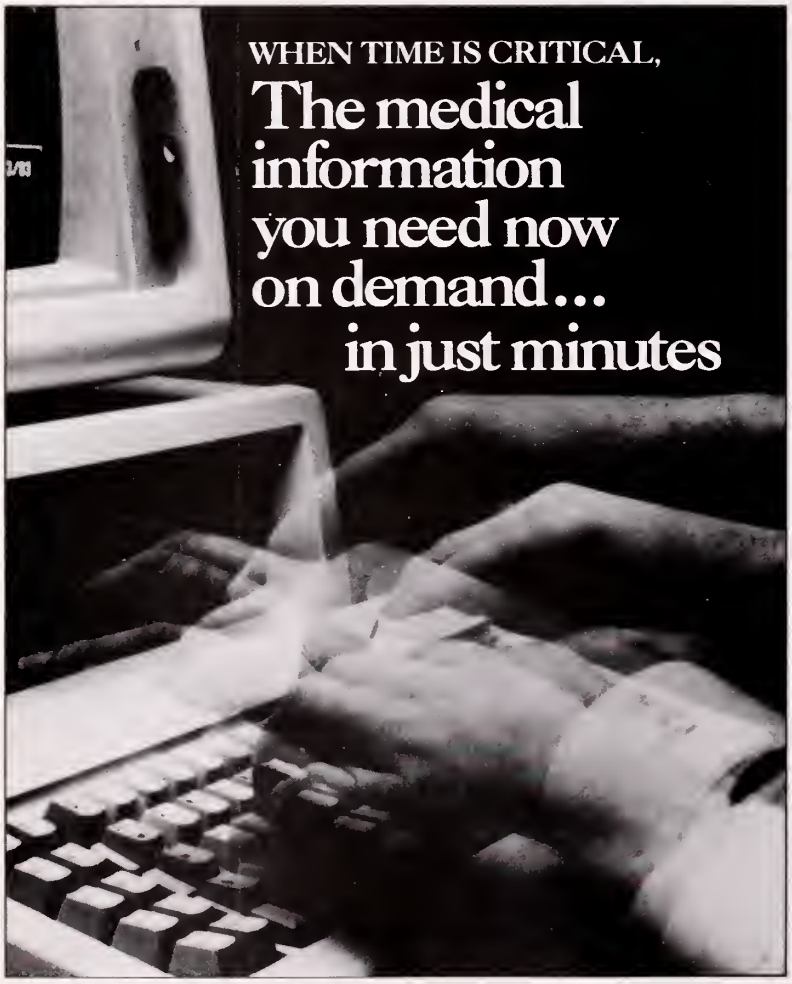

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FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Dr. Weiner to Fill Cancer Society Professorship

Roy Weiner, M.D., professor of medicine and immunology and medical microbiology, chief of medical oncology and co-director of the bone marrow transplant program at the University of Florida College of Medicine, has been named an American Cancer Society Professor of Clinical Oncology.

The professorship is supported by a five-year, $200,000 grant from the American Cancer Society and is designed to further professional education through the support of outstanding faculty clinicians in the cancer field. Grant applications are reviewed and approved by the society's national board of directors.

The grant will allow Dr. Weiner to evaluate and revise the College of Medicine curriculum in cancer, with the aim of fostering cooperation among a wide range of clinical and basic science disciplines through an emphasis on multidisciplinary contact. This interdisciplinary cross-fertilization will touch all areas of oncology education at UF, and involve students, faculty, staff, fellows and postgraduate students.

A UF College of Medicine faculty member since 1976, Dr. Weiner is widely recognized for his contributions to the management of acute myelogenous leukemia, a cancer that affects 7,000 Americans each year, and kills 80 percent of its victims within five years.

Dr. Weiner and his co-researchers developed a treatment regimen that increased the survival rate by administering potent anti-cancer drugs during a short time period.

He and his associates also pioneered in the successful freezing of bone marrow stem cells extracted from cancer patients undergoing bone marrow transplantation therapy. The cell-freezing process greatly aids in monitoring the effectiveness of treatment and in assessing the degree of a patient's recovery.

Dr. Weiner, who received his medical degree from the State University of New York, is president and serves on the board of directors of the Alachua County unit of the American Cancer Society. The author or co-author of more than 100 professional journal articles, he also is a member of the International Society for Experimental Hematology, the American Association for Cancer Research, the Transplantation Society and the American Society of Clinical Oncology. He is past president of the Florida Society of Clinical Oncology.

Joint Commission Changes Autopsy Standards

Medical staffs in accredited hospitals will soon be required to establish criteria to determine when autopsies should be performed. The Joint Commission on Accreditation of Healthcare Organizations adopted the revised standard in December, which also includes a provision for incorporating autopsy findings into the hospital's quality assurance activities. The new standard will become effective for survey on January 1, 1989.

"The Joint Commission has always emphasized the importance of the autopsy as a valuable aid in evaluation of the quality of care and in continuing professional education," said Dennis O'Leary, M.D., Joint Commission president. "But since 1970 there has been a progressive decline in the frequency of autopsies on patients dying in the hospital. These revised standards are expected not only to increase the number of autopsies, but also to increase the relevance of autopsy findings."

It is estimated that the autopsy rate 20 years ago was close to 50%. By 1980 it had dropped to about 14% in community hospitals and 38% in teaching hospitals. Certain groups have advocated that the Joint Commission establish a required minimum autopsy rate to help reverse this decline. However, as Dr. O'Leary explained, "It remains clear that no single rate is appropriate for all hospitals."

The Joint Commission has also shortened the time within which completed autopsy protocols should be made part of a deceased patient's medical record. The revised standard now requires such protocols to be in the patient record within 60 days of the autopsy, unless exceptions for special studies are established by the medical staff.

McCollough Becomes First Vice President of Orthopaedic Association

Newton C. McCollough III, M.D., became first vice president of the American Academy of Orthopaedic Surgeons in ceremonies at the organization's 55th annual meeting in the Georgia World Congress Center on February 8.

Dr. McCollough, the director of medical affairs at the Shriners Hospitals for Crippled Children and a professor in the department of orthopaedic surgery at the University of South Florida, will assume the Academy's presidency at its annual meeting in 1989 in Las Vegas.

As director of medical affairs for Shriners Hospitals for Crippled Children, Dr. McCollough oversees all medical activities of the 22 Shriners Hospitals located throughout the United States, Canada and Mexico, where all medical care and services are provided to children under the age of 18 free of charge. Nineteen of the hospitals are dedicated to treating orthopaedic problems in children, and the three Shriners Burns Institutes provide care for severely burned children.

In addition to his position at Shriners and his professorship at the University of South Florida, Dr. McCollough serves as an orthopaedic consultant to Jackson Memorial Hospital, Miami; Shriners Hospitals for Crippled Children, Tampa unit; and the Bureau of Crippled Children, State of Florida.

Dr. McCollough has authored numerous scientific articles, served as editor on a variety of books, and lectured extensively both in the U.S. and abroad. His achievements have been recognized in "Who's Who in America" since 1982.

DEAN'S MESSAGE

Reduce Enrollment?

The 1987 Legislature required that the three medical schools in the state submit a plan to reduce enrollment. That plan was submitted to the Board of Regents in January 1988.

While a medical manpower study and plan may be desirable, several issues have not been addressed. First, the state's osteopathic school continues to expand and no plan for enrollment reduction was required. Secondly, most physicians who enter practice in the state enter from one of the residency programs in the state. No plan to review graduate medical education exists. Thirdly, the influx of U.S. citizens who attend medical school outside the nation has not been addressed. Florida is now the fourth largest and the most rapidly-growing state.

Finally, if one assumes that state government should provide an access for its citizens to obtain a medical education, then one should review the facts. Florida ranks 46th in the nation in the number of residents entering medical school per 100,000 population. Further, in 1986, there were 138 Florida residents attending medical school outside the state but within the United States. These figures could be used to argue for the development of another medical school in the state — instead of reducing enrollment in the three allopathic schools.

For your information . . .

William B. Deal, M.D.
Dean and Associate Vice President for Clinical Affairs
College of Medicine
University of Florida

ENCORES!

My Worst Successful Case

When I was asked to write this article, the case that leaped to mind wasn't actually "mine"; Bob Snyder was his primary physician, and Gary Hansen first saw him in consultation. But I did become deeply involved with his care, and his story is one which deserves telling.

It began on a September day in 1983. David was a healthy 29-year-old man who lived near a small town about seventy miles from Tallahassee. Thoroughly drunk, he and a friend were riding around in the boonies looking for a good time. What they found instead was a huge Eastern Diamondback rattler, which had the bad judgement to slither across the road within sign of their weaving pickup truck. David decided that its skin would look good on his wall, so he stopped the truck and grabbed it by the tail, trying to drag it into the vehicle. In retrospect, he probably should have killed it first. The snake (apparently a fairly peaceable specimen) managed to escape, and crawled into a nearby ditch. David pursued him, but not being at his most coordinated had the misfortune to slip, lose his balance, and sit down hard — right on the reptile.

That was too much for the creature, which lost its temper and sank its fangs (4 cm apart) into his calf. The friend (who finally killed the snake) related that it just wouldn't let go of the leg, having to be pried off with great effort. He also told me that once they arrived at the local hospital's emergency room, David finished off a six-pack in the parking lot before going in.

At the local ER the physicians treated him with bite incision and antivenin; and, no doubt impressed by both his clinical appearance and by his pH of 7.14, they called Life Flight.

When he arrived at TMRMC, things didn't look good. He had no obtainable blood pressure, and of course, no urine output. He was massively — almost unbelieveably — diaphoretic, and showed muscle fasciculations everywhere. He also had extreme hemoconcentration, with a hematocrit of 63%; it fell to 23% with the requisite massive volume replacement. He had a severe coagulopathy with thrombocytopenia and intravascular hemolysis; the only thing we could do was give multiple transfusions of blood, packed cells, platelets, and various kinds of volume expanders.

His local problems were no less severe than his systematic ones. He required a posterior compartment fasciotomy and debridement for tremendous local swelling and foot drop. His CPK was 90,000. All our efforts to prevent myohemoglobinuric renal failure (volume expansion, mannitol, bicarbonate) failed completely.

Bob recalls reading through the product information brochure on the antivenin. First, he went through the "mild" effects of envenomation; David had every last one. Then he read through the "moderate" effects. He demonstrated all of them, too. Worst of all, he showed every one of the "severe" effects — except death.

So there we were. His massive diaphoretic volume losses were surpassed only by the enormous leakage of fluids out of his vasculature into his bloated tissues. His fluid excess, when all was said and done, was in the neighborhood of one hundred pounds.

With nowhere to go, he soon began to mobilize it. His lungs filled again and again; the only relief lay in daily (sometimes nightly) hemodialysis. Pulmonary edema, like itches and babies, comes at night; David would go to sleep and awaken with PND. It became a familiar routine. The night nurse would call to announce that David was short of breath again; and my feeble protest (he can't be — we just dialyzed him!) would invariably be overcome by the sight awaiting me when I arrived at his room. His terror at these episodes exceeded anything the snake had engendered. Of course, by this time he was sober.

Sometimes bilateral cortical necrosis — the irreversible destruction of both kidneys — results from massive envenomation and its ensuing coagulopathy. Not here; the tide began to turn. David's kidneys bit by bit regained their function. His dialysis grew farther and farther apart, until finally we could stop. The hundred pounds was gone.

He went home — weak, and limping, still with a bit of a foot drop — but alive.

Before he left, talking with him one night, I couldn't resist a question. "David," I said, trying to find just the right words, "don't you think that grabbing that snake was — well — a dumb idea?"

He looked at me with a puzzled expression. "Doc," he said, "I just had bad luck that day."

Try as I might, I could extract no trace of regret, no admission of error, no rueful confession of stupidity. It was all "bad luck." He had learned nothing. Of course, he did have the snakeskin.

C. William Applegate, M.D.
Tallahassee

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The Wonders of the Golden Fleece Plan

I just got back from an American Academy of Ophthalmology convention in New Orleans. Things look pretty grim for the medical profession. Unfortunately, that means things ultimately will not be so hot for patients, either. The pity is that patients won't realize what is happening to them until it is too late to stop the relentless progress toward mediocrity in medical care.

In a smaller, out-of-the-way section of the convention center, a separate meeting of the AMA was taking place. Of course, I thought this was a gathering of the regional delegates to the American Medical Association. Just for a change of pace from eyeball topics, I slipped into a session the AMA was conducting on "How to Survive the Government and Other Insurance Companies."

It wasn't until the first speaker began to show pictures of crunched automobiles that I realized I was attending a meeting of the Automobile Mechanics Association (AMA). I didn't want to insult any of the lecturers by walking out, so I stuck around for the entire symposium. I'm glad I did, because I learned a lot of interesting stuff.

An expert in extended warranties explained how there was growing unrest amongst automobile owners. He said owners were sick and tired of paying huge repair bills on their cars, and more and more of them were beginning to shop around for cheaper alternatives. Many were joining such organizations as the Golden Fleece Plan, which, for a small monthly premium, would pay for "most" repairs (clients were frequently cautioned to read the fine print). Some notable exclusions were cosmetic paint jobs, smashed grills, removal of ingrown oil filters or any defect that took more than an hour to fix.

Another speaker described how the major insurance companies were beginning to crack down on such things as unnecessary spark plug replacements. They were also planning to reduce their payments for

computer diagnostics, unless the mechanic could satisfactorily explain why a simple dip-stick check wouldn't suffice. Apparently a few of the mechanics in the audience had recently shelled out upwards of $30,000 for their computers, because they were clutching their chests, turning blue and slumping over in their seats. It was an awful sight.

There was much concern that excessive emphasis on cost containment might lead to a lower quality of repair service, but a speaker from the Federal Highway Department assured everyone that quality control boards would be established in every town with an automotive repair shop. "Managed performance" through careful monitoring was the goal, and it would be achieved no matter how many inveterate nincompoops were on the boards. He also said that experts from the Department of Agriculture were preparing manuals for the mechanics to follow, and any deviation from established guidelines would be met with severe punishment — not the least of which would be government confiscation of all socket wrenches from 13 to 19 millimeters in size. The feds always did know how to hit a guy where it hurts.

The biggest problem brought out during the symposium was the reluctance of the federal government and private insurers to include older cars in their maintenance organizations. After all, it's hard to keep costs down if you're going to have to take care of automobiles with serious problems. One solution the insurers implemented was simply to reduce the amount they would pay for repairs on older models and see how many kind-hearted mechanics would rise to the occasion. They felt confident that someone would do the job for less. The implication seemed to be that perhaps a little sacrifice in quality was OK under the circumstances. One of the speakers chose to label the phenomenon as "value," that is, the willingness of the car owner to compromise a little quality for a lower cost.

The final speaker for the American Mechanics Association was a fellow from Eastern Europe. In his country (which shall remain nameless), auto mechanics had steadily declined both in numbers and in quality. Parents were not interested in sending their children to mechanics' school anymore, because the rewards were few and the hassles were many. Since there were so few good mechanics left, the auto makers had to begin manufacturing top-quality, low-maintenance cars and trucks. And that is why vehicles from that country are known the world over for their unsurpassed quality.

As I exited the auditorium after the last speech, I wondered if perhaps American medicine might not learn a lesson or two from the mechanics. Since the thrust in medicine is also to provide easily accessible, high quality care at lower cost, all we would have to do is find some way to keep the really sick patients out of the system, and, to follow the European concept, convince God to manufacture only healthy people in the future.

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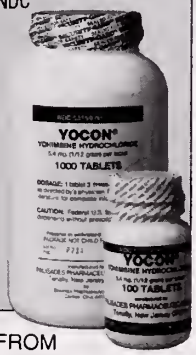

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis
2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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Professor of Medicine, Medical Breast Service, University of Texas, M.D. Anderson Hospital, Houston, Texas

ROBERT CALLAHAN, Ph.D.
Chief, Oncogenetics Section, Laboratory of Tumor Immunology and Biology, National Cancer Institute

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OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
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PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
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Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
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Revised, April 1982. S68S

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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Auxiliary Liaison Editor — Mrs. Charles (Lynn) Moore

Dr. Smith is Sick

The phone rings. "Have you heard? Dr. Smith is sick and can't practice for a while. Helen Smith and the children are just devastated, and really need our help. Can you organize something with the auxiliary to help them through the crisis?"

A call like this brings an immediate response of everything from casseroles to carpooling. Auxiliary members have shown repeatedly an outpouring of caring and sharing to help medical families in time of need — except when the disease is alcohol or drug addiction.

What is medicine's official position on this situation? The AMA guidelines for all medical societies include: "It is a physician's *ethical responsibility* to take cognizance of a colleague's inability to practice medicine by reason of physical or mental illness, including alcohol or drug dependence."

Our own AMA Auxiliary policy supports programs to help impaired physicians and their families; however, "these programs should be initiated *only* with the approval of the state and local medical societies."

Florida's nationally recognized impaired physician program, Physicians Recovery Network, developed and supported by the FMA, has helped hundreds of local doctors recover fully and return to their profession. The success of this program is due in part to elaborate safeguards to the confidentiality and anonymity granted each physician. He is quietly sent off for treatment and rehabilitation.

But what does this mean to the wife and family? If Dr. Smith's illness is a secret, who can Helen Smith turn to? She and the children are left alone while he receives treatment. Not only is she alone and without emotional support, there is a great financial strain without ongoing practice income. Heartbreaking stories are part of this process. Some medical wives in Florida have been forced to go on food stamps to feed their children. Panic, guilt, and depression are common emotions as these women try to cope with life problems they never thought would be a part of their concerns.

To meet the needs of these medical families, a new pilot program was endowed by the Duval County Medical Society Auxiliary in cooperation with the impaired physicians program. A facilitator-therapist who is experienced in the problems of medical families in these difficult circumstances is leading regular meetings for the wives. Not only does this group provide the needed emotional support, but it also gives insight into the problems and possible solutions. And since the success rate for the treatment of impaired doctors increases about 50% when families become involved in the total process, the whole medical community wins. Brochures, lending libraries, and other aides are being added through a grant from the Duval Auxiliary. This pilot program is being used as a model in several counties in Florida and much interest has been shown by other state medical societies around the country.

Unfortunately, the "secret" continues to prevent some wives from receiving help. When one County president was contacted about helping start a group in her locality, she replied, "We just don't have any wives here in that situation." However, the professional staff at the state impaired physicians office had a confidential list of a number of wives from there who had heard of the Duval group and asked for one to be set up locally. Even more sadly, one of these wives needing help was an active, hardworking auxiliary member trapped in the secrecy surrounding Dr. Smith's illness. You may never recognize Helen Smith but she is there in your medical community.

How can you help? Your county auxiliary can schedule programs about impairment and help start local spouse groups through the state Physicians Recovery Network. Only PRN professionals will know the names of medical families you are helping, but your help is needed all the same.

To find out more, write: State Auxiliary PRN Chairman, P.O. Box 2411, Jacksonville, FL 32203. If you need to talk in confidence to a PRN professional about impairment, call the HOTLINE 1(800)-888-8776. (888-8PRN)

Sometimes, casseroles and carpools aren't enough.

Mrs. Howard P. (Janet) Hogshead
Jacksonville

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

MARCH

Office Skills Workshops for the Primary Care Physician, March 2-4, Family Health Center, Orlando. Contact: Orris O. Rollie, M.D. (305) 897-1514.

20th Teaching Conference in Clinical Cardiology, March 2-5, Sheraton Bal Harbour, Bal Harbour. Contact: Michael S. Gordon, M.D., Ph.D., University of Miami (305) 547-6716.

Mid-Winter Seminar in OB/GYN, March 3-5, Don CeSar Resort, St. Petersburg. Contact: James Ingram, M.D. (813) 974-2088.

1988 Florida Conference on Poison Control, March 4, Lincoln Hotel, Tampa. Robert J. McDermott, Ph.D. (813) 974-3623.

9th Annual Advances in Clinical Medicine, March 4-11, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

Advances in the Anterior Segment Cornea, Cataract, Glaucoma, March 6-11, The Yarrow Resort, Utah. Contact: R.J. Gstalder, M.D. (813) 974-3170.

9th Annual Mammoth Mountain Emergency Medicine Ski Conference, March 6-11, Mammoth Lakes, Calif. Contact: Medical Conferences, Inc. 1-800-457-2777.

Cardiovascular and Diabetic Therapy, March 7-9, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

Wound Dressing/Retinoic Acid March 8, Univ. of Miami, Miami. Contact: Larry D. Garland, M.D., P.O. Box 016960, Miami, FL 33101

Intensive Care for Neurological Trauma and Disease, March 9-13, Bal Harbour, Sheraton Bal Harbour. Contact: University of Miami (305) 547-6716.

19th Annual Topics in Internal Medicine, March 10-12, Gainesville Hilton, Gainesville. Contact: Grace Wagner (904) 392-3143.

Current Clinical Concepts in Otolaryngology, March 10-12, Sheraton Bal Harbour. Contact: Division of CME (305) 547-6716.

6th Annual Clinical Management of the Elderly Patient, March 10-12, Buena Vista Palace. Contact: Linda Covert (202) 676-4269.

2nd Annual Oncology Conference, March 10-11, Peabody Hotel, Orlando. Contact: Wendy J. Henry (305) 897-1600.

Selected Issues in Adolescence, March 11, Harbour Island Hotel, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

23rd Annual Meeting, American Society of Contemporary Medicine & Surgery, March 11-14, Diplomat Hotel, Hollywood. Contact: John G. Bellows, M.D. (312) 951-1400.

Ventilators & The Ventilated Patient, March 12, Guest Quarters Hotel, Tampa. Contact: W. Michael Alberts, M.D. (813) 972-7543.

ACLS Instructor Course, March 12-13, Univ. of South Florida, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

Highlights in Women's Health Care, March 16-19, Embassy Suites Hotel, Orlando. Contact: Sharon Stermer (817) 774-2677.

Problems in Rheumatology, March 16-19, Don CeSar Beach Resort, St. Petersburg Beach. Contact: Bernard F. Germain, M.D. (813) 974-2681.

FMA Leadership Conference, March 18-20, Omni Jacksonville Hotel. Contact: Dawn M. Gerik (904) 356-1571.

Team Management in Patient Care, March 21-22, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

Pediatric Goldcoast Conference, March 21-23, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (305) 650-6236.

10th Annual Family Practice Review, March 21-25, Holiday Inn Surfside, Clearwater Beach. Contact: Frances Adams (813) 893-6156.

5th Annual International Breast Cancer Conference, March 24-26, Hotel Intercontinental, Miami. Contact: Nancy Garrett (305) 557-1600.

AIDS: Defining the Process, March 24-26, Building TBA, Daytona Beach. Contact: Halifax Medical Center, Educational Services (904) 254-4169

Cancer Conference, March 25-26, Daytona Hilton, Daytona Beach. Contact: Nancy Drane, R.N. (904) 254-4212.

Rigid Fixation of the Facial Skeleton, Walt Disney Village, Lake Buena Vista. Contact: Sandra Fox (312) 908-5962.

9th Annual Advances in Clinical Medicine, March 25-April 1, Park Suites Hotel, Orlando. Contact: Michael Kessler, M.D. 1-800-334-6578.

Spring 1988 Family Practice Review, March 28-April 1, Peabody Hotel, Orlando. Contact: Grace Wagner (904) 392-4321.

Board Review Course in Geriatrics, March 28 - April 1, Radisson Plaza Hotel, Orlando. Contact: Eric Pfeiffer, M.D. (813) 974-4355.

Estrogen Replacement Therapy in Pre- and Post Menopausal Females, March 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

3rd Annual Controversies in Carcinoma of the Breast, March 31-April 2, Marriott World Ctr., Orlando. Contact: Drs. Clark and King (813) 974-2538.

2nd Annual Advances in Magnetic Resonance Imaging, Marriott World Center, Orlando. Contact: Dr. Clark or Dr. Murtagh (813) 974-2538.

APRIL

Otolaryngology in the Family Practice, April 1-2, USF College of Nursing, Tampa. Contact: James Endicott, M.D. (813) 972-8463.

New Approaches to Common Disorders, April 5-9, Holiday Inn Surfside, Clearwater Beach. Contact: Joel Gleason, M.D. (813) 397-5511.

1988 Florida Tutorial, April 6-8, Airport Marriott, Orlando. Contact: Sally O'Neill, Ph.D. (402) 280-4016.

Issues and Advances in Pediatrics, April 7-9, Sheraton Sand Key Hotel, Clearwater Beach. Contact: Herbert Pomerance, M.D. (813) 974-4214.

7th Annual Sportsmedicine Seminar, April 8-9, Holiday Inn, Pensacola. Contact: Garth Gove, M.D. (904) 474-7101.

Issues in Perinatal Care - 1988, April 8-9, Indigo Lakes Conf. Ctr., Daytona Beach. Contact: Mrs. N. Drane (904) 252-4701.

Challenges in Quality Assurance and Utilization Review, April 9, Tampa. Contact: Kathryn Corrigan, M.D. (813) 497-3340

Current Concepts in Pharmacology of Substances of Abuse and the Medical Management of Detoxification, April 14-16, Pensacola. Contact: Joy Harriman (904) 932-9375.

American Hospitals on Human Values: 1860-1988, April 14-16, Hyatt Hotel, Tampa. Contact: Lois Nixon, Ph.D. (813) 974-3294.

Focus on Education, April 18-20, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

GREM IV - Toxicology/Neurology, April 18-22, Lincoln Harbour Hotel, Tampa. Contact: Registrar (214) 550-0911.

A Week of Medicine, April 18-22, Bonaventure Resort, Ft. Lauderdale. Contact: The Cleveland Clinic, 1-800- 762-8173.

Techniques of Eyelid Reconstruction, April 22, Univ. of Miami, Miami. Contact: Larry Garland, M.D. (305) 547-4477.

Coronary Heart Disease: Current Concepts, April 22-23, Sheraton Royal Biscayne, Key Biscayne. Contact: Deborah Wilderson 1-800-421-3756.

Florida Heart Institute Cardiology Update, April 24-26, Sheraton World Hotel, Orlando. Contact: Rick D. Mace (305) 897-1575.

5th Annual Magnetic Resonance Imaging 1988, April 24-29, Palace Hotel, Lake Buena Vista. Contact: Dept. of Radiology (873-2090.

Continuing Controversies and Dilemmas in Anesthesia, April 29-May 1, Hilton Hotel, Pensacola Beach. Contact: Warren Sears (904) 435-1063.

MAY

Radiology Review Course '88, May 1-6, University of Miami, Miami. Contact: Carol Lamarre (305) 549-6894.

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Of Bureaucrats and Horses or *Why Mediocrity Thrives*

In his latest (1986) book, *The Peter Pyramid*, Laurence J. Peter sagely observes that "an individual with real leadership ability wanting to become a bureaucrat is as likely as a competent jockey wanting to become a horse." Maybe that's why Florida's Lawton Chiles, at the politically tender age of 57, is ready to relinquish his U.S. Senate seat: he's tired of being a horse. Having to pull a plow through a field deep in bureaucratic waste is just one of the burdens Chiles has had to put up with for years.

That there is escalating frustration with the bureaucratic system, as it relates not only to the legislative process but also to everything else it touches, does not surprise me a bit. What does amaze me is that it's taken this long for some major participants to publicly tear their hair out. Apparently, if you let governments fool around with anything long enough, they will eventually ruin it. As we have seen, even the U.S. Senate is not immune to self-destruction.

How about deregulation as another example of good intentions gone sour as a result of too many bureaucratic cooks? Deregulating such industries as the airlines and railroads was supposed to promote competition and thereby lower prices and improve service. But when any business that holds the public's safety in its hands (or seats) begins to cut maintenance costs in order to meet the competitions' prices, then you know the system isn't working.

Now that the government has sunk its teeth so deeply into the neck of medicine, we had better take a serious look at where we are going as a profession. Are we, too, going to be forced to be "cost effective" at the expense of patient safety? I think the answer is already obvious. How many of us have had to answer to a PRO or Medicare for performing an "unjustified" service?

Remember when the federal government declared that there was a critical shortage of doctors and mandated that medical schools double their enrollment? Study after study confirmed the fact that there was a maldistribution of physicians, not a shortage. Now the government says there are too many doctors and, therefore, the profession is ripe for the price-lowering effects of competition. Isn't it fun to look under the physicians' section of the Yellow Pages nowadays? Would you believe that those glitzy, full-page ads (with red borders) are the product of Hippocrates' offspring?

In addition to stimulating competition, with the consequent windfall to the advertising business, the government has frozen Medicare fees, reduced the approved payment for many medical services and increased the insurance premiums to elderly recipients. Make sense? Only to a bureaucratic mind.

Furthermore, in order to induce doctors to accept the frozen or reduced fees, Medicare has resorted to blatant discrimination against physicians who do not "participate" (euphemism for cooperate). For example, what does one call the government's guarantee of prompt payment to participating physicians and, naturally, not-so-prompt payment to the (ugh) nonparticipators? There are no significant allowances for doctors who do much participating on a case-by-case basis, fees are skewed toward the "good guys" and there is no government-sponsored reward for excellence of care. Will government policies like this begin to affect the quality of people going into medicine? Once again, the answers are obvious to everyone except the bureaucrats.

Precisely what is happening in the United States Senate, then, is also happening to the United States medical profession. "The creative individuals, upon whom real change or improvement of the system depend, are outnumbered and overwhelmed by the control-minded conformists intent on formalization, standardization, and unchanging ritualization" (Laurence Peter's words). As a result, the good people are getting out, and top-notch replacements are difficult to find. In a few more years, stifling mediocrity will prevail in both the houses of government and the house of medicine, and I'll bet my diminishing dollar that the services of neither will cost any less.

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those at barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
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Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
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Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
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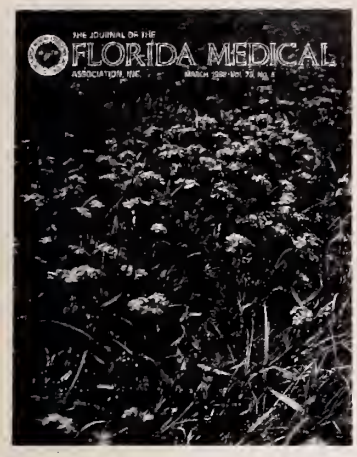

COVER

A lavender array of wildflowers spin their spectacular spring magic beside a rural highway in North Florida. The work of photographer George Neal of Yulee, this month's cover of *The Journal* celebrates the new season in colorful fashion. In keeping with the coming of spring, this edition of *The Journal* features several design modifications that should please readers. The contents page has been completely redesigned with larger numerals, new type styles, and simplified balance and proportion. Inside pages reflect similar changes that we hope will make *The Journal* more functional, readable and relevant to the FMA membership.

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"Okay, so I know I need iron. Where do I get it?

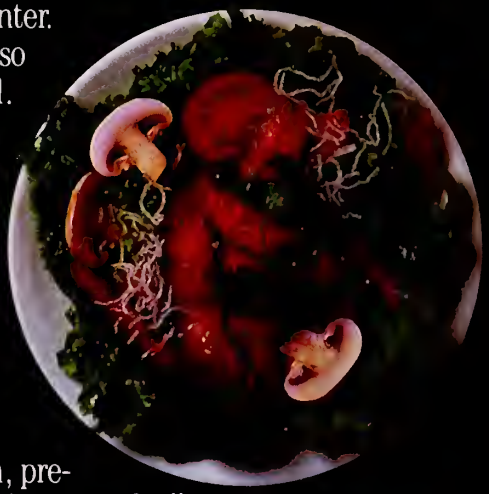
Faced with a Recommended Daily Dietary Allowance of 18 mg, the question is a good one for women aged 19-50. Iron is one of the nutrients most often lacking in the American diet. Low intakes of iron over prolonged time can lead to iron deficiency anemia.

In the 1986 USDA Continuing Survey of Food Intakes by Individuals[1], women of child-bearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg of iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 60 percent of their RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increases the bioavailability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good advice for almost anyone.

Start with "The Skinniest Six" shown below. None is more than 180 calories per three-ounce cooked, trimmed serving. All are easy to specify at the meat counter.



These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And the taste of beef makes it easy to dispense with fat-laden sauces.

Carefully chosen, prepared and served, "The Skinniest Six" provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet beef can be one of the best-tasting recommendations you'll ever make.

BEEF

"The Skinniest Six"*

Eye of Round	Round Tip	Top Loin	Top Round	Sirloin	Tenderloin
1.65 mg iron	2.50 mg iron	2.10 mg iron	2.45 mg iron	2.85 mg iron	3.05 mg iron
155 calories	162 calories	172 calories	162 calories	177 calories	174 calories
5.5 g total fat	6.4 g total fat	7.6 g total fat	5.3 g total fat	7.4 g total fat	7.9 g total fat
(2.1 g saturated fat)	(2.3 g saturated fat)	(3.0 g saturated fat)	(1.8 g saturated fat)	(3.0 g saturated fat)	(3.1 g saturated fat)
59 mg cholesterol	69 mg cholesterol	65 mg cholesterol	72 mg cholesterol	76 mg cholesterol	72 mg cholesterol

Uncooked whole cuts are shown for purpose of identification.

Composite of cooked retail cuts of beef*	
Protein	25.9 g
Iron	2.7 mg
Zinc	6.0 mg
Vitamin B-12	2.28 mcg
Thiamin	.08 mg
Niacin	3.6 mg
Sodium	55 mg
Total Fat	8.7 g
(Saturated Fat)	(3.4 g)
Cholesterol	76 mg
Calories	189

1. United States Department of Agriculture, "Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals. (NFCS, CSFII)" Report No. 86-1. *Nutrients in 3 oz. trimmed and cooked: USDA Handbook 8-13, Rev. 1986.

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For more information: Florida Beef Council, Kissimmee, FL 32742, (407) 846-6221

PRESIDENT'S PAGE

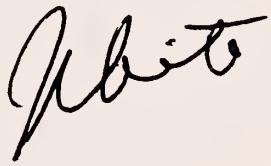
More Work Ahead

As we move swiftly toward March 8th — Super Tuesday — most of the media attention is on the presidential hopefuls. We are all keenly interested in who will be our next President; however, the medical family should view Super Tuesday from another perspective. We need to concern ourselves with getting 300,000 valid petitions signed so that the Florida voters can decide in November if they are willing to support a $100,000 cap on general damages.

It concerns me that many of our membership are reluctant to ask their patients to sign the petitions. Perhaps these physicians feel it will be too time-consuming or embarrassing to ask sick people to help us. Our experience has been very gratifying and we find you need only ask two questions: (1) Are you a registered voter? (2) Will you help us solve this terrible liability insurance crisis?

The only disappointing thing is the number of young people who are not registered to vote. We need to be sure that all of our office personnel and their families are registered to vote and ask them to sign the petitions.

Please remember to thank all of our friends in the Florida Legislature who voted with us during the Special Session. Take the time to drop them a note or call them to let them know that we appreciate their courage in helping us. Remember that the Trial Bar will be going after many of our friends and we must show strong support during the upcoming elections. Currently we have two physicians and two auxilians up for reelection and four physicians running for open seats. All of these good people are deserving of our financial and moral support. This is the year that we MUST support quality candidates, both with money and time.



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Dr. Luis Martin Perez: A Brave Warrior of Medicine

Luis Martin Perez, M.D., a Cuban expatriate who became a voice for freedom, a patriotic American, a civic leader, and the 109th President of the Florida Medical Association, passed away on February 24, 1988, after a long illness.

Born and reared in Cuba, Dr. Perez graduated from the Havana Medical School in 1955. After the revolution and ascendancy to power of the Communist regime, his strong dedication to freedom caused him to leave Cuba for the United States to continue postgraduate training in internal medicine and cardiology at Georgia Baptist Hospital, Atlanta. Upon completion of his training, he served as personnel physician at Florida State Hospital in Chattahoochee for three years, then settled in Sanford in 1963, and commenced private practice in association with his wife, Maria Perez, a dermatologist.

Dr. Perez's love of America soon led him into community service. He was a member of the Sanford Civil Service Board, a trustee of the Central Florida Regional Hospital, Chairman of the Board of the Migrant Clinic in Sanford, and founder of "The Grove," a drug detoxification and rehabilitation center in Seminole County.

He used his talents, enthusiasm and diplomacy in serving his profession and proudly represented the Seminole County Medical Society as a delegate to the Florida Medical Association from 1969 to 1985. Dr. Perez's commitment to the principles of the private practice of medicine led him to continue service on many committees, councils, and the Board of Governors of the FMA, becoming its president in May 1986.

During this time of service to organized medicine, Dr. Perez continued his community activities and received numerous and far-reaching awards, including the A. H. Robins Award for citizenship and community service in 1971, International Human Relations Award by the Dale Carnegie Alumni Association, the George Washington Medal of Honor from the Freedom Foundation at Valley Forge in 1973, and the Benjamin Rush Bicentennial Award of the AMA in 1977.

During his 16-month term as FMA president — the longest of any before him — Dr. Perez confronted a worsening PLI crisis, the on-going problem associated with intrusion of paramedical groups into the practice of medicine, problems with licensing of FMGs, involvement of government into the practice of medicine, and many other critical issues. The challenges he faced were great, but his capacity to meet them was even greater, buoyed by his innate qualities of leadership, determination, and "true grit."

Luis Perez believed in strength through unity, it became his byline, and he diligently and relentlessly traveled the state speaking to every county medical society and as many individual physicians as time permited. To unify their efforts on the PLI issue, he personally led over 4,000 physician members in the rally for liability reform in Tallahassee on April 19, 1986, at which time the FMA spoke with one voice throughout the halls of the Florida legislature. This action, more than any before it, clearly demonstrated to state legislators that the PLI crisis was for real. This "step in the right direction" was the direct result of the strong leadership of Dr. Perez. With the assistance of the Coalition for Liability Reform, his leadership paved the way for recent legislative victories on this very issue.

Dr. Perez always attributed most of his success to the constant loving support and understanding of his wife, Maria, and his sons, Luis Jr., and Tico.

The finest memorial we can dedicate to Luis Perez is to follow and build upon his motto: "In unity there is strength." He was proud to be an American and the legacy he leaves each of us echoes that pride.

Those who knew him respected him; those who knew him well loved him.

Louis C. Murray, M.D.
Orlando

Physician Advertising: Alarming Trends on the Rise

When the Federal Trade Commission issued an order to the AMA in 1982 allowing physicians to advertise, most physicians greeted the action with sneers and a lot of head-shaking. Medicine, after all, had been steeped in a bedrock tradition of long-held ethical values, and advertising was not felt to be part of this tradition. Moreover, physicians did not see any compelling public need to advertise. Most of them were busy and saw no reason to ply their wares beyond the traditional annual listing in the Yellow Pages of the telephone book.

How times have changed! Only six years after the FTC order, there has been a dramatic increase in advertising activities not only among physicians, but also among hospitals, insurance companies, health care plans, and other assorted medical groups. While most of the advertising is legitimate, informative, and helpful, some of what is being offered by physicians to the public today raises questions and concerns in the medical community. Some physicians engage in out-and-out commercialism; some sell services by pandering to the fears of patients, especially the elderly; still others lure patients by tempting offers of no out-of-pocket expenses. Even the listings in the Yellow Pages have undergone a drastic overhaul — they now resemble more and more the listings for lawyers with their glitzy make-up and full-page spreads.

A few examples of what is happening will illustrate why physicians ought to be concerned.

In many cities in Florida, an imaging company advertised as being staffed by board-certified physicians buys expensive advertising space in many newspapers and sets up shop in hotels and motels offering noninvasive studies of the carotids, the heart, and the peripheral circulation. Patients are lured by the promise that early signs of stroke, heart disease, and intermittent claudication can be detected at prices much lower than those offered by local physicians and hospitals. What is not stated is that most of these tests are unnecessary and probably useless. An office visit to the family physician or internist will yield much more information, and at a tiny fraction of the costs.

Some physicians offer so-called screening clinics and public lectures but their ultimate aim is to solicit patients. One of my patients went to such a clinic offering to screen for cancer of the skin and in a few days received a telephone call from the doctor's office informing him that he has a suspicious skin lesion and that his problem can be taken care of, compliments of Medicare. Another patient, who had coronary bypass surgery, got an invitation with other similarly situated cardiac patients to attend a lecture on sexual dysfunction and eventually all were given the doctor's cards just in case they needed his services, also courtesy of Medicare.

More recently, some high-priced physicians have been spending fabulous sums of money drumming up business with intense, high-velocity advertising over the airwaves, in the print media, in health fairs and shopping malls, and almost every place there are large crowds of people. Networks with allied health professionals are also established to further tap the market. But why would such physicians have to be so strident proclaiming to the public their credentials and qualifications? Many physicians are just as qualified, if not more so, but they don't find the need to imitate the antics of Lee Iacocca. If you think that the services offered through this highly-saturated advertising are handsomely reimbursed by Medicare, you guess right.

While some physician advertising no doubt was stimulated by liberalization of the guidelines by both the U.S. Supreme Court and the FTC, most of it has been generated by the intense competition now taking place in medicine. Increasing numbers of physicians are competing for a steadily shrinking health care dollar, and for many physicians it is a matter of doing what is necessary to survive this competition. Advertising (or marketing, as it is euphemistically called in some circles) is one way to get an edge. The prospect of an over-abundance of physicians in a few years is certain to intensify the trend towards increased advertising in the future.

Advertising serves a useful function insofar as it supplies information that will enble patients to make informed decisions concerning their choices of physicians. It should never be misleading or deceitful, and it ought not to be used as an instrument to attract patients when doing so violates ethical guidelines. The public is becoming increasingly aware that a lot of things that may be legal are not necessarily ethical. Unethical advertising practices should not be condoned. The ultimate victims of these practices are the rest of the physicians and the public. Physicians are certain to get a further erosion of their image, while the public will be duped by sleekly-promoted scams.

Only time will tell whether liberal advertising as espoused by the FTC and U.S. Supreme Court will serve the public interest or not. But two things are known at this point: increased physician advertising has not lowered the costs of medical care, as the FTC had expected; and crass commercialism is on the rise. While it is not yet time to sound the alarm like some bar associations have done with some of their members for highly unethical advertising, we ought to be on guard against similar onslaughts by some physicians. If we believe, like Marshall McLuhan, that the medium is the message, we better take a hard look at what that message is.

R. G. Lacsamana, M.D.
Editor

Lessons of History for Trial Attorneys

Recently trial attorneys have lost two very significant battles in their attempt to keep the present tort system unchanged. The first was the law passed by the special session of the Florida Legislature which changed several aspects of the traditional tort system; the second was the decision of the Florida Supreme Court that the $100,000 cap on noneconomic damages could go on the November ballot. The two decisions are major blows to trial attorneys in their fight to keep the status quo.

In looking at the actions of the Florida Academy of Trial Lawyers, it has become clear that the attorneys are repeating some of the mistakes of their old nemesis — doctors. It is amazing that a group of intelligent, highly trained professionals could repeat the mistakes of another profession that, I thought, were clear to everyone in retrospect. Those mistakes, of course, concern the attitude of doctors in the 1950s and 1960s that we were somehow not a part of society. This is a combination of many things, as I have espoused in other editorials, such as increased technology with resultant reliance on tests and a human depersonalization from that reliance; a feeling of the public that the medical profession was losing its original aim of administering to the sick and was instead emphasizing material rewards of being a doctor. As a result of the criticism that began to be directed at medicine, physicians not unnaturally began to isolate themselves from the rest of society and strike out with reactionary attacks.

We soon found out this was a mistake and things only got worse. The prestige of medicine dropped and we had few friends outside the world of medicine. We began to change our approach in the 1980s and opened our world to nonphysicians, tried to recognize that our critics have valid points and listened more patiently to those criticisms and attempted to respond to them. As a result of this change in our attitude, we are less criticized and have even made some friends out of our enemies.

The Academy of Trial Lawyers should have learned from our mistakes. They did not. The attorneys decided that they were answerable only to themselves and strayed from their announced intention of protecting the rights of their clients, an admirable purpose, but a purpose that was usually revered in rhetoric but neglected in practice. Instead, their clients became their victims in many cases with contingency fees of over 50%. Some of the more successful trial attorneys, their methods and life styles have been portrayed in popular magazines with less than enthusiastic reception from the people whose "rights" they are supposedly fighting to preserve. As the magazine articles have showcased their million-dollar homes, the Porsches and the affluent living, the public has begun to cast a skeptical glance at the real motives of trial attorneys.

As if this was not enough, there has been a rash of unbelievable public relations gaffes over the past several years with trial attorneys swooping down on the families of accident victims with avarice and greed oozing from every hair on their heads. In many cases, there was not even an attempt to disguise their true intentions. As a result, anti-attorney jokes are more prominent than ever and remind me of the anti-doctor jokes in the 1960s and 70s.

What happened? The trial attorneys forgot there are limits you cannot exceed in dealing with the public. No matter how exalted you may feel your profession is, or how essential your services are, the public will not stand for arrogant contempt regarding the rest of society. No profession or person is immune from this judgment. This is good and serves as a reminder when a particular profession begins to lose contact with the rest of society and helps to reshape the profession to the needs of the culture in which it operates.

The trial attorneys have not learned from the past mistakes of doctors and will now reap the results of that failure.

I almost feel sorry for them — but not quite.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach

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AIDS and the Physician The Risks . . . and the Rules

AIDS (is there anyone who does not yet know this stands for Acquired Immunodeficiency Syndrome?) has been proclaimed the disease of the 90s. Now reaching epidemic proportions, it has become a buzzword for the limitations of medical science. This as yet untreatable disease has generated hysteria not only in the lay public but also within professional medical circles. The debate over physician responsibility to the AIDS patient as well as to society has made it even as far as ABC's *Nightline*.

The statistics should by now be well known to all physicians. The current estimates are that by 1991 there will be more than 270,000 cases of AIDS in the United States. There are now approximately 1.7 million unsuspected HIV carriers in the United States.[1] The American Red Cross estimates the prevalence to be 38 per 100,000 population; this is confirmed by other studies. The accepted prevalence of HIV carrier status in patients with no known risk factors is 0.04%, compared to 0.8% for the population as a whole.[2] Although staggering, these statistics are impersonal and difficult to comprehend. To paraphrase C. K. Chesterton: nothing is real until it is local. With time, however, physicians in Florida's urban centers will not only have treated someone with AIDS but in all likelihood will have personally known or known of an AIDS victim. Moreover, as the chance of a physician/patient encounter increases, the need for appropriate, intelligent, and compassionate policies are imperative. For the physician working in an emergency department or acute care setting, the need is even more pressing. As studies at Johns Hopkins showed, 3% of trauma patients taken to a trauma center can be expected to be HIV positive.[1] Our own experience at the University of Miami/Jackson Memorial Burn Center corroborates this increased prevalence among burn trauma patients.

Risk and preventing transmission ● Clearly, some contact with patients carrying the HIV virus, or even with frank AIDS, is unavoidable. Since avoiding the patient is not an acceptable approach, practically as well as ethically, physicians must be aware of the risk as well as of the means of prevention of inadvertent transmission of the virus in a health care setting.

In fact, the risks are extremely low. The furor within the medical community aroused by AIDS goes far beyond the actual danger it poses to physicians and nurses. This is not to minimize or belittle the risk but rather to put it in perspective.

While the virus is present in blood, sputum, tears, saliva, semen, and vaginal secretions, transmission to health care workers generally seems to be related to parenteral exposure.[3] The virus, however, is not hardy and the required inoculum is high. For example, transmission of AIDS by an inadvertent needle stick is more rare than perceived, approximately 0.4%.[4] This compares to the more easily transmissible hepatitis B virus in which seroconversion occurs approximately 6-30% of the time after an inadvertent needle stick.[5] Of 1,097 health care workers followed by the Centers for Disease Control (CDC) after a needle stick from a known AIDS patient, only one converted.[6] Of 270 health care workers at San Francisco General Hospital who had high risk exposure to AIDS patients, including 1/3 who had needle sticks, none converted.[7] Thus, the risk from isolated, brief exposure is negligible. Seroconversions after nonneedle stick accidents have occurred only after long exposure to contamination on either skin that was not intact or over mucous membranes. Contamination from saliva through a bite wound is equally rare or nonexistent. No one maliciously bitten by an AIDS patient is an attempt to transfer the virus has seroconverted.

Compliance with well known infection control measures is adequate to protect health care workers working with HIV positive patients. Public Health Service guidelines generally fall into three categories: protective attire and barrier techniques, hand washing, and care of instruments.

Barrier techniques involve the use of gloves for any contact with a wound, dressing, or body fluids. Heavy gloves or a double gloving policy may be prudent. Goggles and masks are advised to prevent splashing onto the face. Nonabsorbent scrub gowns should be used if the possibility of contamination of clothing exists. Since the virus is easily destroyed by simple hand washing with a common disinfectant,

adherence to this standard infection control measure needs little reinforcement. Additionally, it is common sense to avoid doing invasive procedures if one has open lesions or dermatitis on the hands. Meticulous technique around sharp instruments must be maintained, with special attention to detail while doing venipuncture or an invasive procedure. Puncture resistant sharps containers should be placed as close as practical to the area of use for disposal of needles or scalpels. Avoid recapping or breaking/bending needles.

Physicians should be familiar with CDC guidelines and recommendations for prevention of HIV transmission in the health care setting. A 15 page report on this has been published as a supplement to the CDC's morbidity and mortality weekly report.[8]

Responsibilities ● Despite the risks, our legal responsibilities toward HIV positive patients are clear. Discrimination against an individual on the basis of a handicap is specifically prohibited under Section 504 of the Federal Vocational Rehabilitation Act of 1973. Florida is one of the states in which AIDS is expressly named as a protected handicap.[9] These discrimination laws include services and benefits and, thus, medical care. Therefore, while physicians may turn down new patients for a variety of reasons, they cannot refuse to care for a patient solely on the grounds that the patient has, or may have, AIDS. If a patient is refused care, adequate referral or alternative means of medical attention must be secured. Furthermore, if a patient of record is found to have AIDS and is then refused ongoing care, without assistance in obtaining continuity of care, the physician may face charges of abandonment and may be liable if untoward results occur.

Our ethical obligations are no less clear. Our unique position as physicians carries with it a duty that may require us to be exposed to risk. This was true for our medical forebears during the yellow fever epidemics of the 18th century, the influenza pandemic of 1918-1919, and the polio crisis of the 1950s. In fact, the parallel to the influenza pandemic is worth noting. It too was caused by an unknown infectious agent (not identified until a decade later), affected young adults with an unusual lethality, and was untreatable. There were 500,000 deaths in the United States alone, so many that there were shortages of coffins. Nevertheless, physicians did not shirk from attending to the victims.

Long after an AIDS vaccine has been found, society will be left grappling with the ethical questions the AIDS epidemic has left in its wake. Physicians and other health care workers must not be found wanting. While it is important not to minimize the risk of caring for an HIV positive patient, it is also important not to exaggerate those risks. It may be understandably prudent to forego a purely elective procedure on an AIDS patient, but emergency, urgent, and palliative treatments or procedures cannot be denied. Physicians must be mindful that others in society, such as police and firefighters, also take life threatening risks as a matter of daily routine in their work. Our position on the care of AIDS patients should be summed up by the first paragraph of the joint statement issued by the American College of Physicians and the Infectious Disease Society of America in a 1986 position paper on AIDS: "Denying appropriate care to sick and dying patients for any reason is unethical."[10]

References

1. Baker, J.L.; Kelen, G.D.; Sivertson, K.T., et al.: Unsuspected Human Immunodeficiency Virus in Critically Ill Emergency Patients, JAMA 257:2609, 1987.
2. Sivak, S.L. and Wormser, G.P.: How Common Is HTLV-III Infection in the United States? N. Engl. J. M. 313:1352, 1985.
3. Weiss, S.H.; Saxinger, W.C.; Rechtman, D., et al: HTLV-III Infection Among Health Care Workers, JAMA 254:2089, 1985.
4. Lociero, J., III; Quebbemann, E.J., and Nichols, R.L.: Health Hazards in Operating Room, Bull. ACS 72:4, 1987.
5. Gerberding, J.L.; Bryant-LeBlanc, C.E.; Nelson, K., et al.: Risk of Transmitting Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS and AIDS-Related Conditions, J. Infect. Dis. 156:1, 1987.
6. Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients, MMWR 36:285, 1987.
7. Decker, M.D. and Schaffner, W.: Risk of AIDS to Health Care Workers, JAMA 256:3264, 1986.
8. Recommendations for Prevention of HIV Transmission in Health-Care Settings, MMWR 36:(supplement), August 21, 1987.
9. Matthews, G.W. and Neslund, V.S.: Initial Impact of AIDS on Public Health Law in United States-1986, JAMA 257:344, 1987.
10. Zuger, A.: AIDS on the Wards: Residency in Medical Ethics, Hastings Ctr. Report 17:16, 1987.

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Pharmacists and the Right to Prescribe: Ugly "Turf" Battle or Opportunity for Improved Patient Care

Several state legislatures have granted pharmacists a limited right to prescribe selected drugs. Feelings appear to be mixed about their entry into a traditional realm of medicine. Some physicians may feel that pharmacist prescribing authority represents an improper usurpation of the physician's role and dangerously akin to flirtation with "quack" medicine. Budget-conscious state legislators may view the apparent intrusion of pharmacists onto physicians' turf as potentially holding the promise of reduced physician office and emergency-room visits and, in turn, lowered health-care costs. Members of the pharmacy profession may regard their expanded role as a fully appropriate function subsumed within their now-increased lawful range of professional activities.

Legislation ● Recent legislative efforts to grant prescribing authority to pharmacists may be confusing to patients, physicians and pharmacists. It may, thus, be helpful to discuss several of the laws which have been passed, identify and briefly analyze some of the pertinent issues generally raised by such legislation and, perhaps, spell out some thoughts and guidelines which may help focus and assist ongoing professional efforts to grapple with, and hopefully fairly resolve, some of the contentious questions possibly arising from pharmacist prescribing.

California statutory law extends limited prescribing authority to pharmacists.[1] Registered pharmacists in the state shall not be prohibited from performing specified procedures or functions in a licensed health care facility in accordance with protocols developed by health professionals. These functions include initiating or adjusting the drug regimen of a patient pursuant to authorization or orders made by the patient's prescriber and in accordance with the protocols of the pertinent health care facility; ordering drug therapy-related laboratory tests; ordering or performing routine drug therapy-related patient assessment procedures including respiration, pulse, and temperature; and administering drugs and biologicals by injection pursuant to a prescriber's order. Before performing any of these procedures, the pharmacist must receive appropriate training as prescribed in the policies of the pertinent health care facility.

Washington is another state which has legislated in the area of pharmacist prescribing. Relevant provisions of Washington statutory law provide that the "practice of pharmacy" shall include the initiating or modifying of drug therapy in accordance with written protocols or guidelines previously established and approved for his or her practice by a practitioner authorized to prescribe drugs.[2] A pharmacist planning to exercise prescriptive authority in accordance with this provision must have on file at his or her place of practice a properly prepared written guideline or protocol showing that approval has been granted by a practitioner authorized to prescribe.[3] The protocol must include statutorily-specified information.[3]

Florida may have the most comprehensive law enacted to date concerning the legal right of pharmacists to prescribe but their authority is narrowly circumscribed. The laws of Florida permit pharmacists to "dispense" from a formulary. The formulary includes these categories: oral analgesics; urinary analgesics; otic analgesics; hemorrhoid medications; leg cramp medications; antinausea preparations; antihistamines and decongestants; anthelmintics; topical antifungal/antibacterials; topical anti-inflammatory medications; otic antifungal/antibacterial medications, keratolytics; vitamins with flourides; and medical drug shampoos containing lindane.[4] The formulary is established by a "committee" comprised, according to law, of two physicians, one osteopath, three pharmacists, and an additional person with a background in "health care or pharmacology," chosen by the committee. The formulary can be made available to the public upon the order of a pharmacist issued pursuant to a dispensing procedure established by the committee for each drug contained in the formulary.

Ramifications ● The foregoing laws, as well as proposed or possible future state laws regarding pharmacist prescribing, raise sundry issues and have various ramifications potentially affecting patients, physicians, and pharmacists.

Patients in some respects may potentially benefit from an expanded pharmacist role. Those needing prescriptions at night, on weekends or holidays when

their physician's office is closed, may be able to obtain short-term drug therapy and relief until they can see their regular physician. This does not necessarily mean, however, that physician practices will suffer from reduced patient office visits. In fact, an expanded role of pharmacists to include drug prescribing may instead result in more physician office visits. Many persons coming to pharmacists for prescription products may previously have been self-medicating; these persons may now be referred oftentimes by pharmacists to physicians.[5] Although some patients may benefit, others may be confused. In particular, some patients may expect prescriptions for controlled substances or substances outside the lawful prescriptive authority of pharmacists, failing to understand that the pertinent state law grants only highly limited prescribing authority to pharmacists.

Pharmacists may have conflicting, disparate thoughts about laws granting them the power to prescribe. In Florida, for instance, three statewide surveys of druggists reportedly show that only about one out of three is utilizing Florida's pharmacist-prescribing law.[5] Reasons may be varied.[5] Some may fear increases in malpractice premiums or even an inability to obtain coverage. A "fear" of possibly angering physicians may further be diluting pharmacist enthusiasm. Patients may also be angered because of fees charged by pharmacists for the service of prescribing drugs.

The core issue ultimately raised by the pharmacist-prescribing laws is the relative propriety of pharmacists assuming tasks and responsibilities which traditionally have fallen squarely within the realm of clinical medicine. The clinician traditionally will recommend a treatment regimen which may encompass drug therapy. The pharmacist, traditionally, has dispensed drugs in accordance with a prescription order by a physician. Of course, the "dispensing" of drugs encompasses a range of activities intended in part to assure that the patient is provided with the correct medicines, in the right dose, and for the proper period of time. The dispensing function further traditionally includes patient counseling, so that the patient will understand the drug regimen and intended benefits, possible adverse effects and dosing instructions.

Particularly with the advent of state laws granting pharmacists a broadened range of lawful responsibility, clinical medicine, in truth, has become closely commingled with the pharmacy profession. There are now many situations where pharmacists, directly or indirectly, are involved with a patient's drug therapy.[6] The pharmacist may order and evaluate laboratory tests, perform physical assessments, and ultimately choose appropriate drugs in accordance with an approved protocol. Pharmacists may also be involved actively in the development of drug protocols. Patients who choose not to go to a private physician may seek out the advice of a pharmacist with respect to the appropriateness of a particular drug product. Pharmacists may also routinely carefully review prescription orders by physicians for possible errors which may potentially be injurious to the patient.

An expanded pharmacist role in the development of a patient's drug therapy may also create potential risks and problems.[5] A pharmacist, for example, may unwittingly prescribe a drug which may be detrimental to the patient because of a medical problem or condition unknown to the pharmacist. Another scenario may involve the worsening of a clinical problem because the pharmacist has prescribed medication which relieved a patient's pain but thus resulted in a possibly serious problem going untreated.

These potential risks may be associated with the pharmacist's lack of knowledge of data and information which alternatively may be available to the treating physician. The physician, with information collected from a physical examination of the patient, together with appropriate laboratory tests, may not make the types of errors which may be made by a pharmacist not possessing various diagnostic skills. Yet, the potential risks emanating from an expanded role of the pharmacist in the drug prescribing process are outweighed by the potential gains for the patient. But this will likely only be true if the two professions work together in a mutually respectful, cooperative spirit. If they do, their increasingly overlapping functions and responsibilities may result in improved patient care. If they do not, then the divisiveness between two professions both intimately involved with the patient care process may well work to the detriment of patients.

References

1. California Business and Professions Code, Section 4046.
2. Revised Code of Washington, (RCW) 18.64.011 (11).
3. Washington Administrative Code, (WAC) 360-12-140.
4. Chapter 21S-18 "Prescriptions of certain medicinal drugs by pharmacists", Section 18.001 et seq.
5. Feber, S.: What Happens When the Law Lets Pharmacists Prescribe, Medical Economics 13:23 (July), 1987.
6. Penna, R.P.: I Don't Call It Prescribing, American Pharmacy NS26(11):25-28, 1986.

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Some Thoughts on MIRA and the Future

On Sunday March 6, I went to my office in the Mercy Professional Building in the Coconut Grove area of Miami to get a white coat so I could see a patient in consultation at the hospital next door. I picked up the stack of mail that had been shoved through the mail slot of my office door on Saturday and rifled through the large number of envelopes and magazines. Among the mail delivered to me was the March 1988 issue of *Miami Medicine*, official journal of the Dade County Medical Association. I was once Editor of this journal and still serve on its editorial board.

DCMA President Richard Glatzer, M.D., a Miami orthopedic surgeon, wrote a rather long monthly editorial which amounted to a freewheeling menage of thoughts about the malpractice situation. He attacked the Florida Legislature for enacting MIRA in special session, which he apparently believes is a betrayal of the desperate needs of physicians and organized medicine in this state. While attacking the Legislature in general, Dr. Glatzer belittled one specific Dade legislator in a most villainous and cruel way. How such a personal attack on an elected official can improve future chances for legislative relief escapes me.

Also in Saturday's mail was my copy of *FMA Today*, much of it devoted to the passage of the MIRA legislation. The *FMA Today* articles, with pictures of Rep. Sam Bell and a vote count of the legislators on the MIRA bill, described the passage of the legislation as a great victory for the FMA and for all physicians in this state. Mr. Bell is lauded as a hero of the legislation and a friend of physicians. Plans for a constitutional referendum for a $100,000 cap on pain and suffering are still under way, but victory in the special session, according to *FMA Today*, is sweet indeed.

What is the average hardworking physician to think, we the storm troopers of the medical profession, toiling in our offices and hoping for relief from the burden of high liability insurance rates and the declining prestige of our profession? What are we, the little guys providing care to our patients each and every day, to believe when our leaders arrive at such discordant opinions on the very exact same issue? How can one leader tell us that MIRA was a good thing and that we have done well while another tells us that we have been betrayed by both the legislature and our FMA brethren?

And if we are confused, we who practice medicine and have a great personal economic interest in malpractice legislation, then what degree of confusion can we expect from our elected officials who must leave their jobs as teachers, sheet metal dealers or insurance salesman to spend 60 days in Tallahassee each spring representing us in the legislative branch of our state government? They must deal with issues that affect every single aspect of life in Florida, from used cars to preservation of the mangroves swamps; from potholes in state-supported highways to hotel room taxes and overcrowding at state penitentiaries. They can't possibly learn every aspect of every issue they must vote on and they must quickly sort through conflicts created by opposing lobbying groups, so that a consensus can be reached which will benefit the greatest number of Floridians as well as the legislator's constituents and supporters.

The malpractice issue has been complex because three powerful groups, lawyers, doctors, and insurance companies, have been embroiled in an issue of major importance with conflicting goals and no easy solution. It has not always been clear which group best represented patients' rights, since all laid claim: lawyers defending the plaintiff's right to a jury trial and contingency fee system, and physicians defending patients' rights to economical and high quality medical care.

But this special legislative session had a new twist; physicians came with a proposed legislative package that was supported in some aspects by the trial bar but opposed by some county medical societies and practicing physicians around the state. Even the sponsor of the bill, the FMA, appeared intent on withdrawing or at least confusing its support for the legislation just as the session approached.

What could most of the individual legislators do? They gave up several days from their working lives and from their families and homes to travel to Tallahassee to deal with legislation that had been worked out in Committee; legislation that had been proposed by the Academic Task Force after nearly two years of hearings and deliberations; and legislation that the FMA had sponsored and walked through committee with the aid of powerful allies like Sam Bell and Doc Myers. And just as the long awaited session had finally arrived at great expense to the state treasury and to the FMA, some uncertainty existed as to the real value of support for the bill among the bill's main pro-

ponents, doctors and their organized representatives.

I have thought at times that I could never be a politician in Florida or elsewhere because I believe too passionately in certain ideals and I am not certain that I could reach the compromise that is required for good government in a complex democratic system such as ours. It is much easier to compromise, however, on issues that have little or no economic or social importance for ourselves, and it is a good thing that the Legislature is composed of people from so many different occupations and social groups. Legislators must act dispassionately on complex issues that affect all Floridians and they must do so in a way that benefits the most people at the least cost in terms of suffering and economic loss.

We should be grateful that legislation was passed that makes some attempt to improve an unpleasant malpractice situation. Changes can and should be made during the regular 1988 session to improve the bill. For example, the cost of no-fault care of brain damaged babies should be borne by all Floridians and not by the medical profession alone.

Physicians should make plans to continue to improve the climate in which medicine is practiced in this state, primarily for our patients but for ourselves as well. We cannot hope to have the Legislature listen to us if we argue among ourselves and if we make personal attacks on individual legislator's abilities or their intellects.

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Revised, April 1982. S68S

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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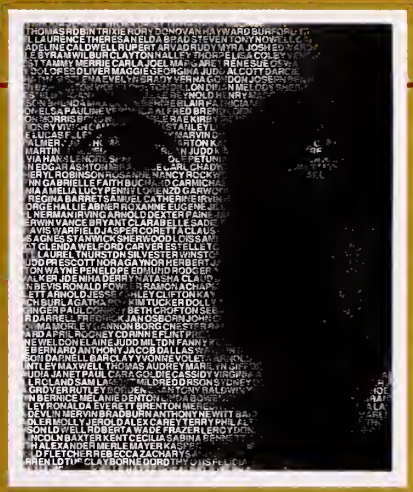

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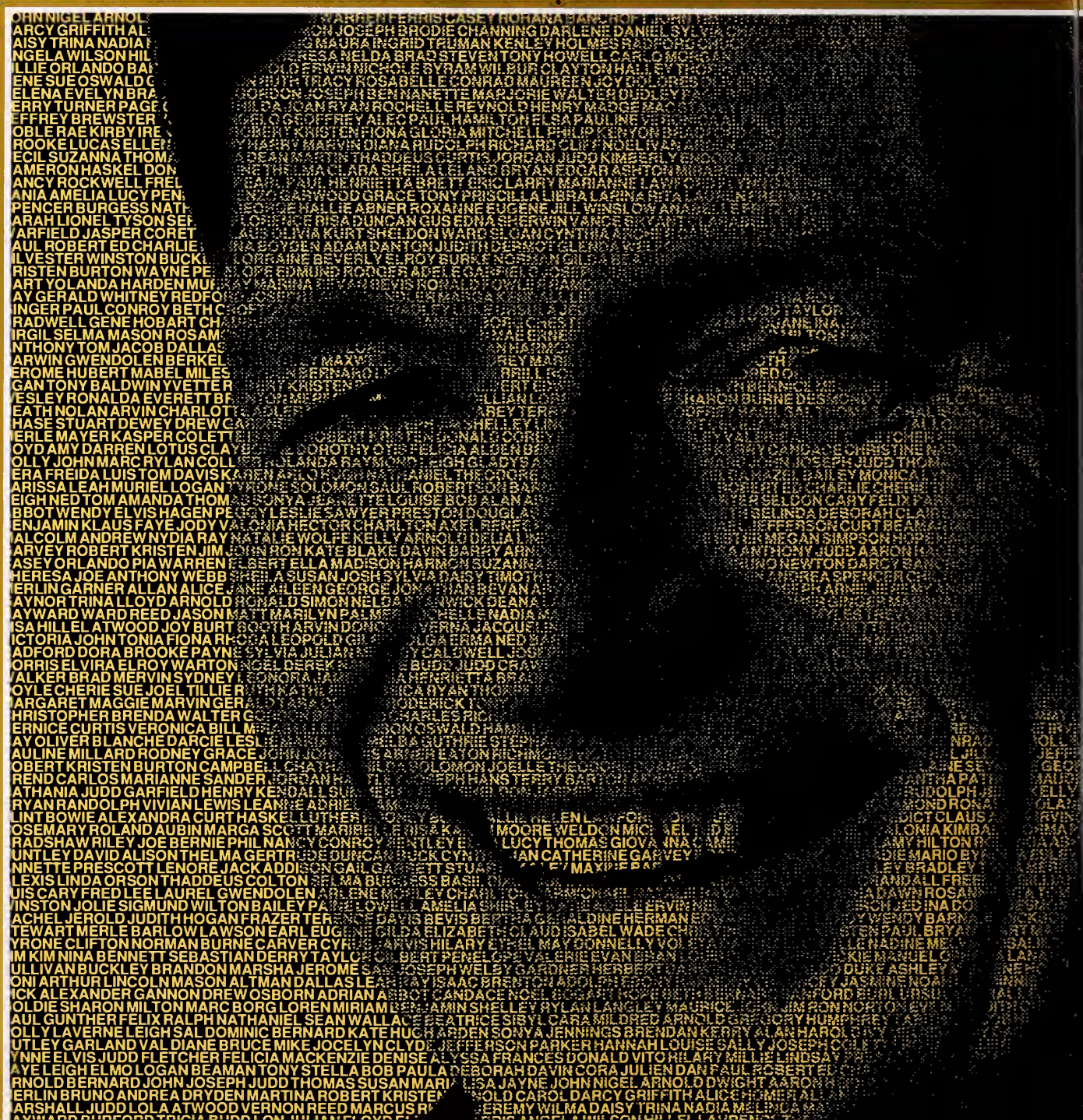

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INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated INDERAL LA good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe INDERAL LA.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with INDERAL LA to be as good as, or better than, other beta blockers.

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

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INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES 60, 80, 120, 160 mg

The one you know best keeps looking better

60 mg 80 mg 120 mg 160 mg

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

WYETH AYERST

PHILADELPHIA, PA 19101

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Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L73B Date of issuance Apr. 1987

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
MARCH 1988 Vol. 75, No. 3

Crossing the Border From Munchausen to Malingering

Warren F. Gorman, M.D., F.A.C.P., and Mark Winograd, M.D.

ABSTRACT: Malingering or shamming illness is the exaggeration or simulation of disease to obtain money, receive drugs or evade responsibility. Malingering is a purposeful act and is not a disorder or disease; it is not diagnosed but instead is detected. Munchausen syndrome is a self-caused disorder in which patients compulsively inflict medical and surgical injury on themselves and by their dramatic and false complaints obtain drugs, hospitalizations, and operations. Two patients with Munchausen syndrome are presented, showing one crossing the border into malingering. A table demonstrates many similarities and some differences between the two conditions.

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One of the most difficult diagnostic problems in hospital and community medicine is the Munchausen syndrome,[1-3] a disorder of peregrinating problem patients[4-9] who have chronic factitious illness and physical symptoms.[10-13] Equally vexatious but more often seen in the medical office or clinic is the detection problem posed by malingering. Formerly called malingery, this is not a physical or mental disorder[14-16] but is instead the act of simulating or exaggerating disease in order to obtain compensation, evade duty, receive drugs, evade criminal responsibility or some similarly understandable goal. Some patients who merit the diagnosis of Munchausen syndrome also perform the act of malingering at the same time.[17,18]

We report two cases on the borderland between this disorder and nondisorder and will contrast the diagnosis of Munchausen syndrome with the detection of malingering.

Diagnosis of Munchausen syndrome ● Classified as a factitious disorder, "factitious" meaning made by man, this disorder often begins in early adulthood and continues with admissions to many different hospitals. Aliases are often used unless welfare benefits supervene. Self-inflicted medical or surgical injury is usual, with factitious fever,[8,9] dermatitis, bleeding,[10,19] and abscesses. The signs and symptoms are limited only by the creativity, cunning and medical experience of the patient. Complaints of pain and demand for drugs, with drug dependence, are frequent. The patient shows great familiarity with medical terms and procedures and frequently is a health professional.

The patient's history is dramatic, fanciful and false, but at first seems marginally plausible. There may be pathological or uncontrollable lying including

florid descriptions of unwitnessed and unverifiable epileptic seizures.[20] The patient may complain of abuse as a child, and seduction and malpractice by physicians. Examination may show multiple surgical procedures with a gridiron abdomen, burr holes in the skull, residuals of myelograms,[12] unnecessary sympathectomies, and other operations, but no physical disorder accounts for the clinical picture.

The DSM III[14] asserts that although these acts of self-harm are voluntary, deliberate and purposeful, they have a compulsive quality and are, therefore, not controllable, thus allocating them among the mental disorders. Most often, such a patient also shows a severe personality disorder.

Detection of malingering ● Malingering is the false and fraudulent simulation or exaggeration of physical or mental disease or defect.[14,16] Malingering is performed in order to obtain money, receive drugs, evade civilian or military duty or criminal responsibility. The reasons for this performance are readily understood by an objective observer on learning the individual's circumstances. Malingering is not a mental disorder[14] and may be performed by apparently normal children,[21] students, test subjects[22] and persons trained for medical instruction.[23]

Malingering is an act which can also be performed by persons with physical and mental disorders. These mental disorders include the traumatic neuroses, the hysterias and the factitious disorder with physical symptoms, which is the Munchausen syndrome.

Since malingering is not a disease or disorder but is instead a sociomedical act, it is not diagnosed but detected. Some details of successful malingering, which being successful cannot be detected, are unknown. The report of malingering, unless the evidence in the physician's hands is as clear as is the proof in court of a smoking gun, should be made cautiously using the term "probable malingering."[24]

Table 1.

SYMPTOMATOLOGY	MUNCHAUSEN	MALINGERING
Falsified symptoms	Yes	Yes
Dramatic symptoms	Yes	Yes
Lying	Yes, but uncontrollably	Yes
Imposture	Yes	Yes
Acts of self-harm	Yes	Probable
Personal gain from symptoms	Yes	Yes
Received disability compensation	Yes	Probable
Familiar with medical terms	Yes	Yes
Familiar with medical procedures	Yes	Yes
Many hospital admissions	Yes	Unknown
Chronic sick role	Yes	Probable
Many surgical procedures	Yes	Probable
Substance abuse	Yes	Probable
Personality disorder present	Yes	Probable
Caused by physical disorder	No	No

Case 1 ● A 25-year-old right-handed female claimed that while shopping in a store a hollow fiberglass mannequin of the upper body, natural size, became unbolted, fell from a table 30 inches high and struck her head. She said that she had a previous seizure disorder which was aggravated by this head injury and that this aggravated seizure disorder later caused her to have an automobile crash, which resulted in her becoming paraplegic. She sought damages from the store.

Emergency room examination two hours after the alleged head injury reported no loss of consciousness, a superficial 2 cm contusion of the occiput, negative general and neurological examination and negative x-ray of the skull and cervical spine.

Previously there had been several admissions for cellulitis as well as others for headache, breast pain, seizures, overdoses of phenobarbital and other medications, respiratory depression, urinary retention and urinary infection. Other problems included hyperthyroidism, gall bladder disease and leg weakness. Neurologic studies then and later, which included electroencephalograms, electromyograms, nerve conduction velocities, visual auditory and somatosensory evoked potentials, all showed no nervous system deficit. The retrieved record contains 13 CAT scans and four myelograms, all normal. Medication for pain included Dilaudid every three hours, later adjusted to 12 methadone tablets daily. She reported a previous craniotomy but no evidence of this operation on skull x-rays could be found. Her diagnoses included "hysteria" and "factitious etiology".

At 25, the mannequin event took place. She then complained to a rehabilitation specialist of respiratory and general weakness and diminished sensation below the neck and a diagnosis was made of possible C6 quadriplegia. She was given a wheelchair and urged to diminish medication dosage. She continued to drive her automobile.

Four months later there was an automobile accident either while she was sitting alone in her parked car or was parking. Extensive orthopedic and neurologic and laboratory examinations showed no

quadriplegia or any musculoskeletal or neurologic damage.

At 27, this plaintiff was examined attended by her mother and lawyer. The mother spilled the urine specimen and a blood level for drugs could not be taken because of thrombosed veins. The plaintiff, in a motorized wheelchair, had her mother briefly remove her oxygen mask.

Mental status examination showed an alert, responsive and oriented young woman without an organic brain syndrome or signs of aphasia. Motor status showed a severe weakness in all four extremities despite normal tendon and superficial reflexes. On sensory examination, she reported diminished perception of all stimuli on the trunk and extremities below a line at the junction of the neck with the thorax, except that there was a sacral sparing with an anal wink.

Diagnosis was: 1. Munchausen syndrome, or chronic factitious disorder with physical symptoms; 2. Probable chronic intoxication with prescribed medications; 3. No structural disorder of the nervous system. Probable malingering was noted.

Outcome: Defense counsel believed that the exposure of this young woman in a motorized wheelchair wearing an oxygen mask would prejudice a jury toward her and she was given a settlement.

Case 2 ● The second patient is a 36-year-old male nurses aide with pathologic obesity (160 kg) and a history of many hospital admissions for recurrent abdominal pain, chest pain, ''barking'' cough, hematemesis, dyspnea, hematuria and other complaints for which no physical basis was found, as well as for surgery on the left knee for a minor trauma to the lateral meniscus.

In August 1986 he was admitted because of severe left-sided chest pain, weakness of the left arm and leg and difficulty in speaking but no neurologic abnormalities were found on examination. The EEG, CT scan, spinal tap and carotid angiography were all normal and his symptoms remitted.

During the following eight weeks, weakness of the left arm and leg briefly reappeared and then remitted several times. Because a psychogenic cause was suspected, an amytal interview[25] was performed. During this interview, the patient moved his left arm and hand well. But when he was shown that he was moving this extremity, he denied it saying that since he was paralyzed he could not move it. Shortly afterward, however, he returned to his previous level of functioning.

Four months after remission of paralysis, he was admitted again for abdominal pain and a diagnosis was made of incarcerated ventral hernia. At operation, a 2 cm lipoma was found in the superficial fascia of the abdominal wall, halfway between the xiphoid process and the umbilicus. Surgical review suggested that there had been neither a hernia nor an incarceration of the bowel.

Conclusion ● As noted in Table 1, there are many similarities between the Munchausen syndrome and malingering. In the Munchausen syndrom, the patient cannot control his behavior and also has ''an intrapsychic need to maintain his sick role.''[26] On the other hand, the act of malingering consists of the performance, often a dramatic one, of a deceptive medical act. This act can be readily recognized by learning the individual's objective circumstances rather than his individual psychology.[14]

While patient 2 shows familiar features seen in a general hospital of the Munchausen syndrome, patient 1 appears to have crossed the border into malingering.

Appendix

Terminological note ● When Asher in 1951 gave its present name to this condition, he was well aware that the genuine Baron, Hieronymous Karl Friedreich, Freiherr von Munchausen, had told amusing and imaginative stories of his travels, military and sporting exploits, in private social gatherings. But an embezzler, Rudolph Eric Raspe, anonymously published in 1785 ''The Singular Travels, Campaigns and Adventures of Baron Munchausen'' which became a best-seller by telling fascinating but outrageously false tales and, thus, associated the name of Munchausen with mendacity. The real Munchausen was then unable to take legal action against Raspe because of the latter's anonymity and peregrinations, particularly after Raspe was accused again of swindling and fled to Ireland.[12]

Asher's rejection of the obvious eponym, ''Asher's Syndrome,'' for this condition is understandable, for what proper British physician would like his name associated with such unsavory behavior? Perhaps with this in mind, Asher chose the term ''Munchausen Syndrome'' unfortunately adding ridicule to two centuries of defamation of that true raconteur, the genuine Baron.

To clear Munchausen's name and because of the frequent hospital admissions in this condition, we suggest that it be called nosocomotropism, from the Greek words nosocome, for hospital, and tropism, for seeking.

References

1. Asher, R.: Munchausen's Syndrome, Lancet 339-341, Feb. 10, 1951.
2. Cramer, B., et al: Munchausen Syndrome, Arch. Gen. Psychiat. 24:573-578, 1971.
3. Bursten, B.: On Munchausen's Syndrome, Arch. Gen Psychiat. 13:261-268, 1965.
4. Bagan, M.: Munchausen Syndrome, Boston Med Quart. 113-119, Sept. 1962.
5. Chapman, J.: Peregrinating Problem Patients, JAMA 165:927-933, 1957.
6. Ireland, P., et al: Munchausen Syndrome, Amer. J. Med. 43: 579-592, 1967
7. Davis, D. and Weiss, J.M.A.: Malingering and Related Syndromes. In Arieti, S. (ed.): American Handbood of Psych. Basic New York, Volume 3, pp. 270-287, 1974.
8. Reich, P. and Gottfried, L.A.: Factitious Disorders in Teaching Hospital, Ann. Int. Med.: 99:240-287, 1983.
9. Aduan, R.P., et al: Factitious Fever and Self-Induced Infection, Ann. Int. Med., 90:230-242, 1979.
10. Gorman, C.A., et al: Metabolic Malingerers, Amer J. Med 48:704-714, 1970.
11. Clarke, E. and Melnick, S.C.: Munchausen Syndrome and Problem of Hospital Hoboes, Amer. J. Med. 34:6-12, 1958.

12. Henderson, L.M., et al: A Neurosurgical Munchausen's Tale, J. Neurol. Neurosurg. Psychiat. 46:437-439, 1983.
13. Keschner, M.: Simulation (Malingering) in Relation to Injuries of Brain. In Brock, S. (ed.): Injuries of Brain and Spinal Cord and Their Coverings, 4th Edition, p. 410, Springer, N.Y., 1960.
14. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Washington, D.C., 1980.
15. Boydstun, J.A.: Malingering. In Kaplan, H.I., et al (eds.): Comprehensive Textbook of Psychiatry, 3rd Edition, Williams and Wilkins, Baltimore, 1980.
16. Gorman, W.F.: Defining Malingering, J. Forens. Sci. 27:401-407, 1982.
17. Novello, J.R.: Practical Handbook of Psychiatry, C.C. Thomas, Springfield, p. 37, 1973.
18. Miller, H. and Cartilage, N.: Simulation or Malingering in Relation to Injuries of Brain and Spinal Cord. Feiring, E. (ed.): Brock's Injuries of Brain Spinal Cord, Springer, N.Y. 1974.
19. Schmaier, A.H.: Factitious Heparin Administration, Ann. Int. Med. 95:592-596, 1981.
20. Riley, T.R. and Roy A.: Pseudoseizures, Williams and Wilkins, Baltimore, 1982.
21. Soiffer, A.: Children Who Deceive Psychologists, J. Clin. Psychol. Spring, 27-28, 1975.
22. Anastasi, A.: Psychological Testing, 5th Edition, Macmillan, New York, 1983.
23. Barrows, H.: Simulated Patients: (Programmed Patients), C.C. Thomas, Springfield, 1971.
24. Gorman, W.F.: Malingering: Detection and Reporting, Ariz. Med., 41:179-183, March, 1984.
25. Perry, J.C. and Jacobs, D.: Overview: Clinical Application of Amytal Interview in Psychiatric Emergency Settings, Amer. J. Psychiat. 139:5:552-9, May, 1982.
26. Sussman, N. and Hyder, F.: Factitious Disorders. In Kaplan H.I., et al: Comprehensive Textbook of Psychiatry, 3rd Edition, Williams and Wilkins, Baltimore, 1982.

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Pneumothorax, Pneumomediastinum, and Pneumopericardium: Complications of Cocaine Smoking

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ABSTRACT:* Pneumothorax, pneumomediastinum, and pneumopericardium have well documented multiple etiologies. We present two cases of pneumomediastinum, one in conjunction with pneumopericardium and the other with pneumopericardium and bilateral pneumothoraces, following repeated valsalva maneuvers to increase the "high" during cocaine smoking.

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Case 1 • An 18-year-old male presented to the emergency room complaining of left-sided chest, back, and shoulder pain and painful swelling of the neck. The patient stated that the onset of symptoms occurred approximately six hours prior to admission after he had smoked one gram of "crack" cocaine. The patient reported that after each deep inhalation, he would hold his breath and "bare down" thus increasing the "high." Physical examination was positive only for crepitus over the neck and supraclavicular fossae bilaterally. A PA chest roentgenogram demonstrated bilateral apical pneumothoraces, pneumomediastinum, pneumopericardium and subcutaneous emphysema in the anterior neck and both supraclavicular fossae (Fig. 1).

Conservative therapy was initiated (without thoracostomy tubes). The patient's recovery was uneventful and he was discharged four days after admission with complete resolution of the pneumothoraces and pneumopericardium and near complete resolution of the pneumomediastinum and subcutaneous emphysema.

Case 2 • An-18-year-old male presented to the emergency room with a 1½ hour history of dizziness, shortness of breath, and crushing midsternal chest pain that increased with inspiration and activity. The patient admitted to having been "free basing" cocaine with unusually deep inspirations and valsalva maneuvers prior to the onset of symptoms. Physical examination was positive only for a pericardial rub. A PA chest roentgenogram demonstrated the presence of pneumomediastinum, pneumopericardium and a small right sided effusion (Fig. 2). The patient was treated conservatively and discharged two days after admission upon resolution of symptoms. Moderate resolution of the pneumomediastinum and pneumo-

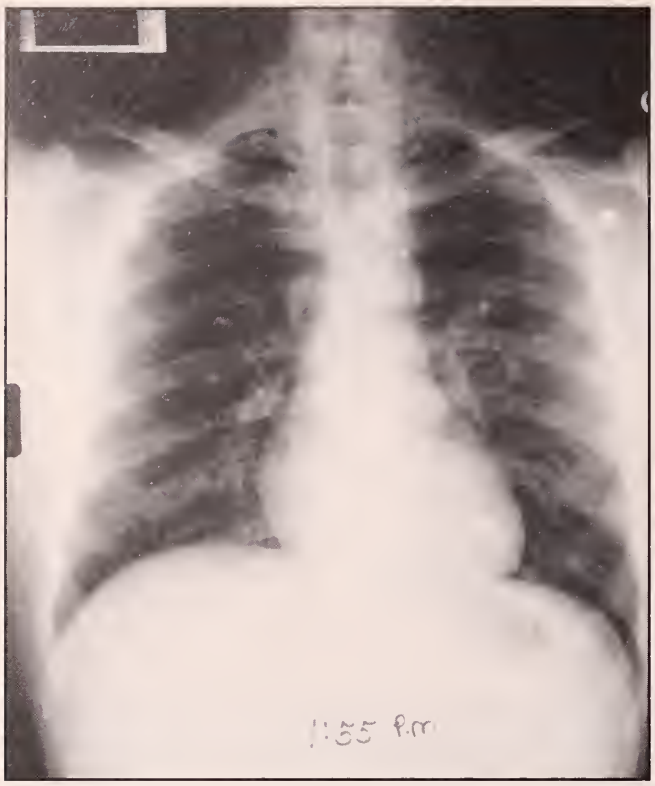

Fig. 1.—PA chest roentgenogram at the time of admission demonstrates small bilateral apical pneumothoraces, pneumomediastinum and pneumopericardium.

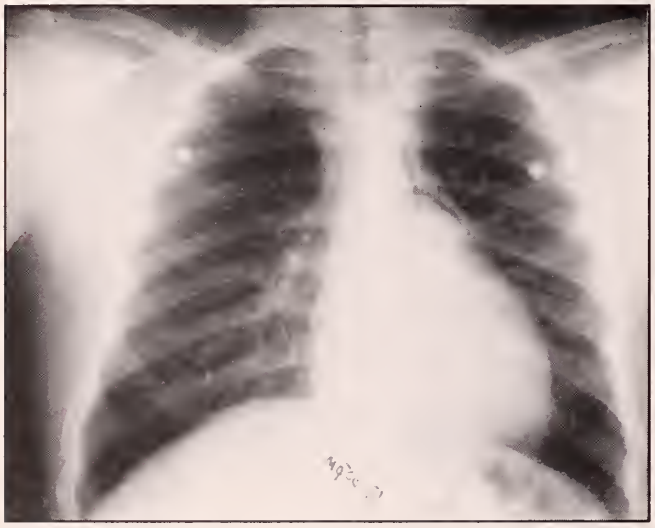

Fig. 2.—A PA chest roentgenogram at the time of admission reveals pneumomediastinum and pneumopericardium without pneumothorax and a small right-sided effusion.

pericardium had occurred. The effusion resolved completely.

Discussion • Spontaneous pneumothorax among healthy males occurs most commonly during the third to fourth decade. Rupture of an apical bleb was emphasized by Kjaergaard in 1932 as the most common etiology of unilateral pneumothorax.[1] These subpleural blebs frequently occur on both lungs, however, simultaneous bilateral pneumothoraces are rare.[2] Less commonly gas escaping from a ruptured bleb may dissect centripetally along lung and hilar structures resulting in spontaneous pneumomediastinum. The occurrence of both spontaneous pneumothorax and pneumomediastinum in otherwise healthy patients is rare. Spontaneous pneumomediastinum and pneumopericardium is at least as equally rare.

Blunt chest trauma may result in pneumomediastinum in up to 40% of patients. Associated pneumothorax can occur in anywhere from 10 to over 50% of cases.[3] Valsalva maneuver during childbirth, defecation, or exercise may increase intrathoracic pressure enough to cause alveolar rupture. Macklin and Macklin[4] suggested that during this maneuver the collapse of pulmonary vessels and expansion of adjacent alveoli result in disruptive shearing forces capable of tearing alveolar walls and the visceral pleura with resultant pneumothorax. Air may also or alternately enter the pericapillary interstitial space dissecting along the periarterial-peribronchial and perivenous sheaths en route to the mediastinum. From the mediastinum, gas may dissect along the great vessels, aorta, and mesenteric vessels, or esophagus, resulting in neck and facial air, pneumotosis intestinalis, or pneumoretroperitoneum and pneumoperitoneum respectively. Pathways from the mediastinum to the pericardial sac may result from dissection through the pericardial reflections of the pulmonary vessels.

The pathophysiology of pneumothorax, pneumomediastinum and pneumopericardium is probably related to the valsalva maneuver with high intrathoracic pressure. Cocaine itself is most likely not the culprit as spontaneous pneumomediastinum has been associated with marijuana smoking and valsalva maneuver.[5]

In summary, in this day and age, discovery of bilateral pneumothoraces, pneumomediastinum and/or pneumopericardium in an otherwise healthy young patient should raise suspicion of unusual habits or maneuvers resulting in high intrathoracic pressure: suspect cocaine, marijuana, or other inhalation drug abuse.

References

1. Kjaergaard, H.: Spontaneous Pneumothorax in Apparently Healthy, Acta Med. Scand. (Suppl.) 43:1-159, 1932.
2. Fraser, R.G. and Pare, J.A.P.: Diagnosis of Diseases of Chest, Philadelphia, W.B. Saunders, 1970, pp. 1159-1161.
3. Cyrlak, D.; Milne, E.N.; and Imray, T.J.: Pneumomediastinum: Diagnostic Problem, CRC Crit. Rev. Diag. Imag. 23(1):75-117, 1984
4. Macklin, M.T. and Macklin, C.C.: Malignant Interstitial Emphysema on Lungs and Mediastinum as Important Occult Complication in Many Respiratory Diseases and Other Conditions: Interpretation of Clinical Literature in Light of Laboratory Experiment, Medicine (Balt.) 23:281-358, 1944
5. Christie, R.V. and McIntosh, C.A.: Lung Volume and Respiratory Exchange After Pneumothorax, Q. J. Med. 5:445-454, 1936.

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Osteonecrosis of the Femoral Head

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***ABSTRACT:** Necrosis of bone has become a major clinical entity within the past 20 years. Femoral head involvement has particular clinical significance with early diagnosis and treatment often proving difficult. We present a series of 25 affected hips diagnosed by functional bone investigation and treated by core decompression. When decompression is performed prior to onset of subchondral collapse 77.7% of patients are asymptomatic at follow-up. Once collapse has occurred, however, 73% of our patients showed early failure. By reviewing this topic and results of functional bone investigation and core decompression, we hope to make clinicians more aware of precipitating factors as well as alternative methods of diagnosis and treatment.*

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Osteonecrosis, first described by Koenig in 1888,[1] is characterized by death of bone cells followed by remodeling of vulnerable parts of the skeleton. Its significance as a clinical entity affecting the femoral head in young to middle-aged adults has risen dramatically. In 1962 Mankin[2] found only 22 cases of necrosis of the femoral head in the English literature and concluded that it was a relatively rare condition. More recently, however, Streda[3] reported that 68% of 235 patients studied with supposed degenerative joint disease had osteonecrosis as the underlying unrecognized cause. Bullough[4] stated that 18% of femoral heads he removed at autopsy had osteonecrosis as the primary diagnosis. This apparent rise in incidence is due to increased prevalence of factors implicated in its formation as well as greater awareness of its existence.

Understanding of this condition has been clouded by the names given to it. Terms such as *avascular necrosis, ischemic necrosis, aseptic necrosis, nontraumatic necrosis, posttraumatic necrosis, osteochondritis dissecans,* and *idiopathic necrosis,* reflect death of osteocytes due to nutritional failure at the cellular level. With the exception of posttraumatic necrosis they do not clarify the causative mechanisms of the condition.

Posttraumatic (avascular) osteonecrosis ● In posttraumatic necrosis there is interruption of vulnerable vessels supplying the femoral head. The medial and lateral circumflex arteries anastomose to form an arterial ring at the base of the femoral neck. Posteriorly three retinacular branches arise from this ring, pass beneath the capsule and ascend to supply the femoral head (Fig. 1). The superior retinacular arteries enter the superolateral aspect of the femoral neck to become the main intraosseous artery of the head. A displaced fracture at the base of the neck or a dislocated hip can either tent the vessels or primarily disrupt them resulting in avascular necrosis.

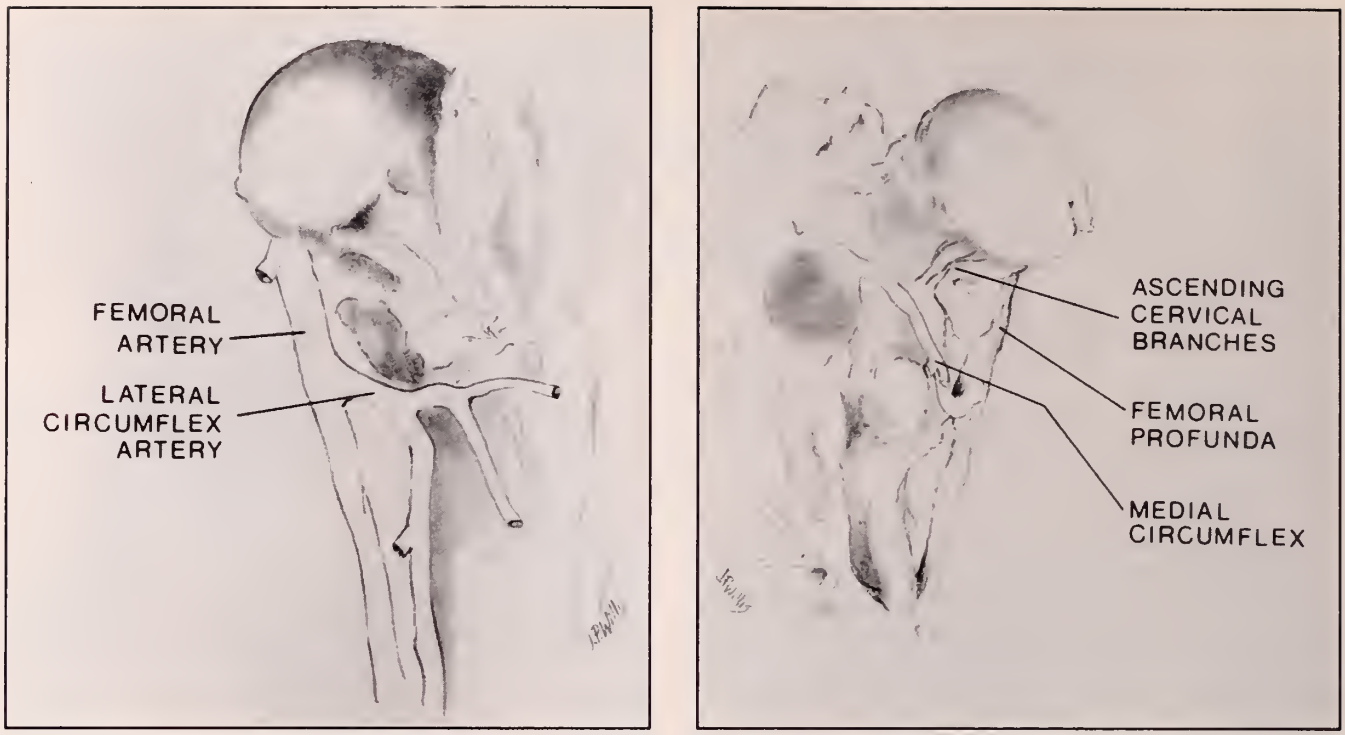

Fig. 1.—Blood supply to the femoral head, (left) anterior view, (right) posterior view showing the retinacular branches arising from the anastomotic ring.

Idiopathic osteonecrosis ● Nontraumatic necrosis has as yet no proven etiology. Numerous factors have been associated with its onset including steroids, both endogenous and exogenous, Gaucher's disease, systemic lupus erythematosis, alcohol abuse, gout, thrombophlebitis, sickle cell disease including S.C. and s-thalassemia, and caisson disease.

In 1960 Dubois and Cozen[5] described an association between osteonecrosis and systemic lupus erythematosis with an incidence of joint involvement estimated between 5-10%. Klippel,[6] however, believed the incidence of subclinical, asymptomatic and nonprogressive involvement may be in excess of 30%. These figures are difficult to confirm in view of the complicating influence of steroids which so many of these patients are receiving. Steroid use has been reported to be associated with 14-36% of all cases of osteonecrosis.[4] Other contributory factors have also been associated with a high incidence. Kawashima et al[7] reported that femoral head necrosis developed in 59.5% of Japanese divers treated for decompression sickness. Alcohol abuse has been reported as associated with 17-74% of all cases of osteonecrosis while a 21-48% incidence has been reported in patients suffering from hyperuricemia or gout.

Etiology ● A number of theories have been proposed to explain the cause of idiopathic osteonecrosis of the femoral head. In corticosteroid users Nishio[8] and Sugioka[9] found thickening of the walls of arteries and arterioles in the capsule and ligamentum teres and concluded that a steroid induced vasculitis leads to a relative hypovascularity. This microscopic vascular picture, however, has not been a constantly reproducible finding. Boettscher et al[10] contended that steroids alter the coagulation system leading to intravascular thrombus in subchondral bone. Jones and his associates[11] postulated that corticosteroids lead to formation of a fatty liver from which fat embolism occurs. They demonstrated the presence of fat stainable material in the femoral head and other organs, presumably of embolic origin. Glimcher and Kenzora,[12] however, shed doubt on this theory by demonstrating equal amounts of fat stain in normal controls. Wang et al[13] implicated hypertrophy of lipocytes in the bone marrow of the femoral head. As fat cells increase in size, venous outflow becomes obstructed leading to a rise in intraosseous pressure. Eventually the pressure elevation restricts arterial inflow causing hypoperfusion of the marrow cells.

Different theories have been proposed for the genesis of dysbaric osteonecrosis in caisson disease. The gas bubbles produced may cause primary disruption of the vascular supply. They may induce osmotic shifts of fluids leading to redistribution of blood flow; or they may set off a sequence of events, i.e., thrombosis, platelet aggregation, vessel injury, lipid embolism, which impede bone marrow circulation.[4]

Others have suggested that as yet unidentified cytotoxic agents affect marrow cells in alcohol and steroid induced cases.[12] Wagner and Zeiler[15] felt that idiopathic osteonecrosis is a systemic disease

predominately affecting the femoral head and other vulnerable parts of the skeleton. They pointed to vascular fragility, loss of skin elasticity and other soft tissue changes as evidence of this sytemic involvement.

Diagnosis ● Femoral head necrosis typically presents with intermittent deep throbbing pain in the inguinal area which may radiate to the medial thigh and knee. This pain often eases but recurs eight to 12 weeks later with intensity proportional to the patient's activity level. Physicial examination reveals limited and painful abduction and internal rotation.

Plain x-rays are used in staging the disease process. Several classifications have been proposed but Ficat's[16] is easy to understand, has useful clinical applicability, and, thus, has gained wide clinical acceptance.

Stage I is termed preradiographic and shows either no changes or only mild osteoporosis (Fig. 2). Stage II demonstrates cancellous changes appearing as diffuse or spotty sclerosis and/or osteoporosis (Fig. 3). Stage III is characterized by collapse of the femoral head with the joint line remaining intact (Fig. 4). Stage IV shows flattening and loss of width of the joint line suggesting acetabular changes (Fig. 5).

Bone scans may be helpful in early diagnosis. Numerous isotopes have been used as scanning agents and can be separated into two categories, showing activity of osteocytes or of the reticuloendothelial cells of the bone marrow. Uptake of bone seeking isotopes, such as technitium 99 polyphosphate,

Fig. 3.—Stage II osteonecrosis with cyst development in both femoral heads (left more advanced than right). Previous core decompression has been performed on left.

Fig. 2.—Stage I osteonecrosis with only mild osteoporosis present. Patient has undergone previous core decompression.

Fig. 4.—Stage III osteonecrosis demonstrating collapse of the femoral head.

Fig. 5.—Stage IV osteonecrosis with loss of width of the joint line showing both femoral head and acetabular degenerative changes.

depends on intact blood supply and new bone formation in the femoral head. These radioisotopes, unfortunately, are nonspecific and show osteoblastic activity which may be due to trauma, fracture healing, osteoarthritis or remodeling following necrosis. Bone marrow cell scans may show the earlier changes in osteonecrosis since these cells are believed to be the first affected. According to Turner[17] technitium 99-m antimony demonstrates changes within 24 hours following loss of nutrition to the marrow and specifically the histocytes. Unfortunately, normal adults may also show diminished or absent activity in the proximal femur due to loss of hematopoietic elements, thus decreasing the diagnostic usefulness of the scan.

Recently, newer noninvasive methods have been shown to detect early osteonecrosis. Dihlmann[18] and others[19,20] have found computerized axial tomography with multiplanar reconstruction to be more accurate than conventional radiography in defining changes within the femoral head. Of most interest, however, is the use of magnetic resonance imaging. Because the marrow cavity emits a strong MR signal any alternation in the fat or marrow cells, with subsequent ingrowth of vascularized mesenchymal tissue, will be detected early in the process.[12] As the disease progresses, increases in the bone density from compaction will lead to reduction in the MR signal. This should allow determination of alteration in viability prior to radiographic changes.[19,21]

Functional bone investigation ● Functional bone investigation evolved because of continued uncertainty with early diagnosis of osteonecrosis. In 1938 Larsen[22] reported an association between elevated bone marrow pressure and bone necrosis. The proposed mechanism is development of an intraosseous compartment syndrome with the increased pressure in the closed space compromising the vascularity.

Functional bone investigation consists of two steps. First a 3 mm cannula is introduced percutaneously through the lateral femoral cortex into the base of the femoral neck. Pressures are measured both initially and following a 5 cc injection of normal saline. An intraosseous venogram is performed by injecting water soluble radiopaque contrast into the femoral head. Abnormal values are defined as: an initial pressure reading greater than 30 ml of mercury; a rise in pressure of 10 ml of mercury for 5 minutes following the saline injection test; or minimal filling of the extraosseous veins on venogram with diaphyseal reflux below the lesser trochanter.[23]

Decompression by removing a 9 mm diameter core from the necrotic segment in the head accomplishes two objectives: confirmation of the diagnosis of osteonecrosis by histological examination and release of pressure in the femoral head. This procedure is done under general or regional anesthesia. Partial weight bearing is maintained for six to eight weeks.

There is good correlation between results of functional bone investigation and biopsy. In early stages of osteonecrosis, Zizic et al[24] reported 93% of Stage I and Ficat[23] reported 97% of Stage I and II patients having positive hemodynamic studies. A wide variability of results, however, has been reported in the treatment of femoral head necrosis by core decompression. Marcus et al[25] in 1973 reported good results in ten of 11 Stage II patients with a follow-up of two to four years. Ficat reported radiologic deterioration in 21.5% and clinical failure in 8.3% of his Stage I and II patients at 7.5 years follow-up. Zizic et al[26] while still recommending core decompression reported less favorable results for Stage I and II patients with almost one third of them developing recurrent symptoms and x-ray progression at an average of 2.8 years follow-up. Camp and Colwell[27] recently showed a 60% failure rate at a mean follow-up of 18 months in their 20 patients seen prior to collapse. In view of this wide discrepancy we reviewed our results of core decompression following functional bone investigation.

Clinical study ● Nineteen patients (eight male, 11 female; average age 42.9 years) with 25 affected hips (13 right, 12 left) were studied at the University of Connecticut Health Center in Farmington. Follow-up was between 27-46 months (average 33 months) post-core decompression. Contributory factors were noted in 16 patients including chronic steroid use in nine, significant alcohol history in three, previous trauma

in two, short-term steroid use in one and sickle cell disease in one. All patients were evaluated preoperative by functional evaluation using the Harris hip score,[28] radiographic staging of the hip by the Ficat classification and radionuclide bone scan. Nine hips were classified as Stage I, one as Stage II, 14 as Stage III and one as Stage IV. Functional bone investigation was then carried out, followed by core decompression.

Failure was defined by any one of the following:

1. Clinical deterioration as determined by the Harris hip score.
2. Recurrent symptomatic complaints.
3. Radiographic deterioration.
4. Subsequent major surgery on the affected hip.

Good results were defined as patients who were both asymptomatic and had at least a ten point improvement on their Harris hip score.

Results ● Nine patients (two male, seven female) with 11 affected hips had good results. Seventy-seven and seven-tenths percent (77.7%) of Stage I and 28.5% of Stage III patients were thus classified. Ten patients (six male, four female) with 14 affected hips were termed "failures" (22.2% of Stage I, 71.5% of Stage III and one patient each from Stage II and Stage IV) (Table I).

Table 2 shows the relative diagnostic accuracy of the three components of the functional bone investigation. Among the patients having good results following core decompression, 80% had an elevated initial pressure (average pressure 41 mm of mercury), 40% had a positive stress injection test and 40% had a positive venogram. In the "failure" group 70% had elevated initial pressures (average pressure 37.5 mm of mercury), 77% had a positive stress injection test and 66% a positive venogram. Of the 23 hips in which initial intraosseous pressures were recorded, 17 were found to have elevated values. Five of the remaining six hips had either a positive stress injection test or a positive venogram. The venogram showed the poorest accuracy as only 50% of patients with osteonecrosis had an abnormal study. Overall hemodynamic studies correlated with the biopsy proven diagnosis of osteonecrosis in 95.6% of cases.

Complications ● There were no intraoperative or postoperative fractures or infections. In our initial study group there were no complications with the trephine although in a subsequent patient this did break. It was removed with the cored bone.

Discussion ● By combining the three hemodynamic studies in functional bone invetigation, excellent correlation (95.6%) was obtained with the biopsy-confirmed diagnosis of osteonecrosis. In Camp and Colwell's[27] recent series, computerized tomographic scans and magnetic resonance imaging proved to be 100% sensitive for diagnosis in preoperative testing.

Table I.—Results of Core Decompression in Treatment for Osteonecrosis of the Femoral Head with an Average Follow-Up of 33 Months.

		Good Results	Failures
I	9	7 (77.7%)	2 (22.2%)
II	1	—	1 (100%)
III	14	4 (28.5%)	10 (71.5%)
IV	1	—	1 (100%)
	25	11 (44%)	14 (56%)

Table 2.—Diagnostic Accuracy of the Components of Functional Bone Investigation.

	Pressure (30 mm Hg)	(+) Stress	(+) Venogram
Good	8 (80%) Ave.. Pressure 41 mm Hg	4 (40%)	4 (40%)
Failure	9 (70%) Ave. Pressure 37.5 mm Hg	7 (77%)	4 (66%)

Thus it appears that these could replace functional bone investigation for diagnostic entities.

We believe that treatment by core decompression should continue in the armamentarium of the orthopedic surgeon. The results in our series showed 77.7% of patients asymptomatic at an average of 33 months following core decompression when treated for osteonecrosis prior to the onset of radiographic changes (Stage I). Once subchondral collapse occurred, however, 73% of patients failed treatment by core decompression. These results are especially important in view of the apparent increasing incidence of this entity and the far greater morbidity associated with other means of treatment, i.e., grafts, osteotomies, arthrodeses, surface replacements, and total joint arthroplasties. These procedures certainly have a place in treatment for the more advanced stages as well as in patients who fail the initial core decompression. However, in view of the young age of many of these otherwise healthy patients, early diagnosis by magnetic resonance imaging followed by treatment with core decompression appears to be important diagnostic and treatment modalities.

Acknowledgment

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References

1. Koenig, F: Beitruge zur Atiologie der Corporu Mobilis, Entstehhung derselben durch osteochondritis dissecans, Dtsch. Z. Chir. 27:99-109, 1888.
2. Mankin, H. and Brower, T.D.: Bilateral Idiopathic Aseptic Necrosis of Femur in Adults. Chandler's disease. Bull. Hosp. Joint Dis. 23:42, 1962.
3. Streda, A.: Participation of Osteonecrosis in Development of Severe Coaxarthrosis,

Monogr. XLVI, Acta Univ. Carol Med. Prague, 1971.
4. Jacobs, B.: Epidemiology of Traumatic and Non-traumatic Osteonecrosis, CORR 130:51-67, 1978.
5. Dubois, E.L. and Cozen, L.: Avascular (Aseptic) Bone Necrosis Associated with Systemic Lupus Erythematosus, JAMA 174:966-984, 1980.
6. Klippel, J.H.; Gerber, L.H.; Pollak, L.; and Decker, J.L.: Avascular Necrosis in Systemic Lupus Erythematosis, Am. J. Med. 67:83-87, 1979.
7. Kawashima, M.; Torisu, T.; Hayashi, K.; and Kitano, M.: Pathological Review of Osteonecrosis Indivers, CORR 130:107-117, 1978.
8. Nishio, A. and Yakushiji, K.: Legg-Calve-Perthes Disease: History and Treatment, Yonago Acta Medica 6:1, 1962.
9. Sugioka, Y.: Idiopathic Avascular Necrosis of Femoral Head, J. Jap. Orthop. Assoc. 47:1021, 1973.
10. Boettscher, W.C.; Bonfiglio, M.; Hamilton, H.H., et al.: Non-traumatic Necrosis of Femoral Head: I. Relation of Altered Hemostasis to Etiology, J. Bone Joint Surg. 52A:312, 1970.
11. Jones, J.P., Engleman, E.P.; Steinbach, H.L.; Murray, W.R., and Rambo, O.: Fat Embolization as a Possible Mechanism Producing Avascular Necrosis, Arthritis Rheum. 8:449, 1965.
12. Glimcher, M.J. and Kenzora, J.E.: Biology of Osteonecrosis of Human Femoral Head and Its Clinical Implications: III. Discussion of Etiology and Genesis of Pathological Sequelae; Comments on Treatment, CORR 140:273-312, 1979.
13. Wang, G.J.; Sweet, D.E.; Reger, S.I.; and Thompson, R.C.: Fat Cell Changes as Mechanism of Avascular Necrosis of Femoral Head in Cortisone-Treatment Rabbits, J. Bone Joint Surg. 59A:729, 1977.
14. Chryssanthou, C.P.: Dysbaric Osteonecrosis Etiological and Pathological Concepts, CORR 130:94-106, 1978.
15. Wagner, H. and Zeiler, G.: Idiopathic Necrosis of Femoral Head, edited by Weil, U.H., Springer-Verlag, Berlin, Heidelberg, New York, 1981, pp. 87-116.
16. Ficat, P.; Arlet, J.; Vidal, R.; Ricci, A., and Fournial, J.: Resultants Thereapeutiques du Forage Biopsie dans les Osteonecorses Femoracapitules Primitives, Rev. Rheum. 38:269, 1971.
17. Turner, J.H.: Post-traumatic Avascular Necrosis of Femoral Head Predicted by Preoperative Technitium 99m Antimony-Colloid Scan, J. Bone Joint Surg. 65A(6):786-797, 1983.
18. Dihlmann, W.: C.T. Analysis of Upper End Femur: Asterick Sign and Ischemic Bone Necrosis of Femoral Head, Skeletal Radiol. 8:251-258, 1982.
19. Steinberg, M.E., Kressel, M.Y.; Alavi, A., and Atel, L.: Avascular Necrosis of Hip: Comparison of MRI, CT and Scintigrapby, AJR 147:(1):67-71, 1986.
20. Jergeson, H.E.; Heller, M., and Genant, H.K.: Magnetic Resonance Imaging in Osteonecrosis of Femoral Head, Orthop. Clin. N.A. Oct. 16:(4) 705-716, 1985.
21. Moon, K.L. Jr.; Genant, H.K.; Helms, C.A., et al: Musculoskeletal Applications of Nuclear Magnetic Resonance Imaging, Radiology 147:161-171, 1983.
22. Larsen, R.M.: Intramedullary Pressure with Particular Reference to Massive Diaphyseal Bone Necrosis. Experimental Observations, Ann. Surg. 198:127, 1983.
23. Ficat, P.: Early Diagnosis of Osteonecrosis by Functional Bone Investigation in Segmental Idiopathic Necrosis of Femoral Head, edited by Weill, U.H., Springer-Verlag, Berlin, Heidelberg, New York, 1981, pp. 17-27.
24. Zizic, T.M.; Marcoux, C.; Hungerford, D.S., and Stevens, M.B.: Radiography, Scintingraphy and Hemodynamics: Diagnosis of Ischemic Necrosis of Bone (INB), ARA Annual Meeting Abstract #170, 1983.
25. Marcus, N.D.; Eneking, W.F., and Massam, R.A.: Silent Hip in Idiopathic Aseptic Necrosis, Treatment by Bone Grafting, J. Bone Joint Surg. 55A:1351, 1973.
26. Zizic, T.M.; Marcoux, C.; Hungerford, D.S., and Stevens, M.B.: Treatment of Ischemic Necrosis of Bone (INB) by Core Decompression, ARA Annual Meeting Abstract #107C, 1983.
27. Camp, J.F. and Colwell, C.W.: Core Decompression of Femoral Head for Osteonecrosis, J. Bone Joint Surg. 68A:1313-1319, 1986.
28. Harris, W.H.: Traumatic Arthritis of Hip after Dislocation and Acetabular Fractures: Treatment by Mild Arthroplasty. An End Result Study Using a New Method of Result Evaluation, J. Bone Joint Surg. 51A:737, 1969.

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It means "dependability" in almost any language

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Capsule or tablet slow-release potassium chloride preparations should be reserved for patients who cannot tolerate, refuse to take, or have compliance problems with liquid or effervescent potassium preparations because of reports of intestinal and gastric ulceration and bleeding with slow-release KCl preparations.

Before prescribing, please consult Brief Prescribing Information on next page.

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For patients who can't or won't tolerate liquid KCl.

*The most common adverse reactions to potassium salts are gastrointestinal side effects.

†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

Slow-K®
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8 mEq (600 mg)

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see DVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See DVERDOSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and DVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

DVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the D-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics, (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate, (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED

Tablets — 600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

8 bottles of 100	NDC 0083-0165-30
8 bottles of 1000	NDC 0083-0165-40
Consumer Pack — One Unit	
12 Bottles — 100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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Psychiatric Services Within Florida's Health Maintenance Organizations

Bruce Lubotsky Levin, Dr. P.H.

ABSTRACT: This study presents the results from a 1986 survey of psychiatric services within Florida health maintenance organizations (HMOs). Twenty two of 28 HMOs provided data on organization characteristics, psychiatric benefit coverage, and the utilization of psychiatric inpatient and outpatient services. Results indicated that Florida HMOs provided a median psychiatric benefit coverage of 30 inpatient days and 20 outpatient days similar to coverage found in HMOs located throughout the United States. However, the organizational characteristics of Florida HMOs represented a "third generation" of HMOs in comparison to HMOs located throughout the entire United States: generally for-profit, Individual Practice Association (IPA) type models with enrollments under 25,000 people. Nevertheless, physicians should become familiar with the diversity in the organizational structure of HMOs in order to better understand future interactions they might have with these capitated systems of care.

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The organization, financing, and delivery of health care in the United States remain in an era of major transition. The present strategy in this procompetitive environment involves development of managed health care systems and networks designed to offer a range of integrated medical care services. Regardless of the institutional setting, organizational structure, or the particular services available, the bottom line has increasingly focused on cost containment as well as quality medical care.

One particular arrangement of health care delivery, health maintenance organizations (HMOs), has become an increasingly prominent alternative financing and service delivery system. These organizations have generally provided a specific range of health and medical care services to a voluntarily enrolled population for a fixed, prepaid monthly fee. Organizationally, however, the structure of HMOs have been found to be more heterogenous than previously thought.[1]

Physicians have been associated with HMOs in a variety of ways. The most common has been the prepaid group practice (PGP) or closed panel model in which the HMO contracts with a group of physicians to provide medical care, usually on a capitation basis. In the network model, the HMO contracts with multiple groups of physicians to provide medical care in the medical groups' facilities. In the staff model, the HMO hires physicians to provide medical care, usually on a salaried basis. In the fourth basic model, the Individual Practice Association (IPA) or open panel model, the HMO contracts with physicians to provide medical care in their own offices usually on a capitation or fee-for-service basis. Additional mixed or hybrid structural models of HMOs have also been identified.[2]

Because HMOs have been marketed as providing a range of medical care services, consumers as well

Table 1.—Annual Mean Inpatient and Outpatient Utilization Rates for Selected HMOs in Florida, Southeastern United States, and United States.

Annual Utilization Rates	Geographic Location: Florida	(N)	Southeast Region	(N)	United States	(N)
Inpatient Services						
Days per 1,000 Members	402	(21)	401	(43)	388	(301)
Admissions per 1,000 Members	74		75		74	
Length of Stay per Admission	5.10		4.97		5.18	
Outpatient Services						
Total (Outpatient) Physician Encounters per Member	4.15		3.91		3.68	
Total (Outpatient) Encounters per Member	4.25		4.20		4.24	

as providers may not have realized the extent of the limitations on psychiatric care vis-a-vis other medical care services. While other studies have examined HMO psychiatric services within individual plans[3,4] as well as from a national perspective,[5] this study has provided an initial look at the current benefit coverage and utilization of psychiatric services within Florida HMOs.

Method ● This study was a component of a larger national study which investigated the organizational structure, service coverage, utilization, and costs of medical (specifically psychiatric) services within all operational HMOs throughout the United States. Another paper details the survey methodology.[6]

Results ● In 1986 there were 595 HMOs throughout the United States with a total enrollment of approximately 23.7 million people. For the same year, 40 of these HMOs were in Florida with a total enrollment of approximately 850,000 people. Of the 40, 12 had been operational for less than one year and were omitted from the study. The remaining 28 had been operational for at least one year with an enrollment in excess of 500 people. A total of 22 HMOs returned the self-administered questionnaire, a 78% response rate.

Organization characteristics ● Thirteen of the 22 had enrollments of less than 25,000 people. Fourteen had been operational for less than five years. Eighty-two percent (18) held federal qualification status. There was one group model HMO, six staff models, 11 IPAs, and four network models. Eighteen of the HMOs were located in major metropolitan areas, defined as populations in excess of 500,000, while 21 were for profit organizations.

Psychiatric benefit coverage ● Federally qualified HMOs are required by law[7-11] to provide basic health services to their subscriber population including: (1) short-term (not to exceed 20 visits), outpatient evaluative and crisis intervention mental health services; and (2) medical treatment and referral services for alcohol and drug abuse or addiction. All of the responding HMOs in Florida offered psychiatric coverage as part of their basic benefit plan. While 21 of 22 HMOs offered alcohol and substance abuse coverage, 14 of the 21 restricted coverage to detoxification services.

While federal laws have not mandated minimum inpatient psychiatric benefits for federally qualified HMOs, the median provision for inpatient psychiatric coverage was 30 days per member per year. Eighty-two percent of the HMOs provided for inpatient psychiatric coverage without additional benefit limitations, i.e., assessment of copayment, deductibles, mandatory block periods, or lifetime cost limitations. All 22 HMOs provided for 20 outpatient psychiatric visits per member per year conforming to mandated outpatient psychiatric benefits for federally qualified HMOs. One half of the HMOs required a median additional copayment of $10 per member per visit for outpatient psychiatric services.

Organization of HMO psychiatric component ● Thirteen of the 22 responding HMOs reported having a director of psychiatric services. Eight were psychiatrists, one was a primary care physician, and four were psychologists. A median of one psychiatrist and one psychologist were employed by group and staff model HMOs while a median of nine psychiatrists and three psychologists were affiliated with IPA and network model HMOs. Fourteen of the 22 reported that outpatient psychiatric services were performed in the offices of private psychiatric practitioners while the remaining eight provided psychiatric services in the same building as general medical services. These eight HMOs utilized both psychiatrists as well as

Table 2.—Annual Mean Inpatient and Outpatient Psychiatric Utilization Rates for Selected HMOs in Florida, Southeastern United States and United States.

Annual Psychiatric Utilization Rates	Geographic Location: Florida	(N)	Southeast Region	(N)	United States	(N)
Inpatient Services						
Days per 1,000 Members	30	(19)	33	(39)	38	(270)
Admissions per 1,000 Members	3.85		3.63		3.27	
Length of Stay per Admission	8.16		9.29		11.55	
Outpatient Services						
Total (Outpatient) Physician Encounters per Member	0.21		0.21		0.22	
Total (Outpatient) Encounters per Member	0.29		0.28		0.28	

psychologists for service delivery.

Health services utilization ● Annual mean inpatient and outpatient utilization rates for total health services and for psychiatric services for HMOs in Florida, Southeastern United States,[6] and throughout the United States[6] appear in Tables 1 and 2. Annual hospital days per 1,000 members and outpatient physician encounters per member per year were higher for HMOs in Florida vis-a-vis HMOs in the southeast region and national HMO utilization rates. However, annual inpatient psychiatric days per 1,000 members was lower in Florida than in the Southeastern United States and throughout the United States.

Discussion ● Obviously a major caveat of this study includes the extremely small number of Florida HMOs with complete data on psychiatric services. Nevertheless the benefit coverage for psychiatric services in the 22 responding Florida HMOs was the same as benefits in southeastern and national HMOs:[6] a median benefit of 30 inpatient days per member per year and a median of 20 outpatient visits per member per year. The utilization rates for total medical and psychiatric services were also similar within Florida HMOs compared to regional and national figures.

The major differences appear to be in the organizational characteristics of Florida HMOs vis-a-vis national HMOs. Florida HMOs more closely resembled those in the southeast, perhaps reflective of the evolution of a third generation of HMOs: plans operational for less than five years; enrollments under 25,000; predominantly for-profit, federally qualified HMOs; and health plans with a high percentage of IPA model HMOs. In contrast HMOs nationally were older health plans with larger enrollments, usually not-for-profit, with a more even distribution of model types.

The proliferation and growth of HMOs has reemphasized the importance of the development of integrated health care delivery systems particularly between primary medical care services and psychiatric services. These alternative health care delivery systems have also provided opportunities for the implementation of utilization control and quality assurance.

However, federally qualified HMOs have been required only to provide psychiatric care considered medically necessary and to address conditions amenable to brief treatment.[7-11] These services generally have excluded the chronic mentally ill and elderly populations with psychiatric problems. Thus, there remains limited accessibility to HMO psychiatric services through benefit restrictions and limitations, limited staffing, together with the generic problem of unequal insurance coverage vis-a-vis coverage for other medical services.[12]

With the heterogeneity in HMO organizational structure as well as differences in the organization of HMO psychiatric services,[1,5] physicians, particularly psychiatrists, need to more carefully examine particular HMO model arrangements prior to direct service provision interactions with these organizations.

References

1. Levin, B.L. and Levin, J.D.: Differential HMO Organizational Structures, GHAA J. 7:43-49, 1986.
2. Zelten, R.A.: Alternative HMO Models. Issue Paper Number 3, National Health Care Management Center, 1979.
3. Burnell, G.M.: Phasing-in Mental Health Services in a Health Maintenance Organization: Problems and Issues, Group Health J. 5:29-33, 1984
4. Wells, K.B.; Manning, W.G., and Benjamin, B.: Use of Outpatient Mental Health Services in HMO and Fee-for-Service Plans: Results from a Randomized Controlled Trial, Health Services Research 21:453-474, 1986.
5. Levin, B.L.; Glasser, J.H., and Roberts, R.E.: Changing Patterns in Mental Health Service Coverage Within Health Maintenance Organizations, Am. J. Pub. Health 74:453-458, 1984
6. Levin, B.L.; Glasser, J.H.; Sharinus, M., and Jaffee, C.: Preliminary Findings from 1986 National Survey of HMO Mental Health Services, Florida Mental Health Institute, University of South Florida, 1987.
7. U.S. Congress: Health Maintenance Organization Act of 1973, Public Law 93-222, 87 STAT. 914-936, 1973.

8. U.S. Congress: Health Maintenance Organization Amendments of 1976, Public Law 94-460, 90 STAT. 1945-1960, 1976.
9. U.S. Congress: Health Maintenance Organization Amendments of 1978, Public Law 95-559, 92 STAT. 2131-2141, 1978.
10. U.S. Congress. Health Maintenance Organization Amendments of 1981, Public Law 97-35, 95 STAT. 572-578, 1981.
11. U.S. Congress: Health Maintenance Organization Amendments of 1986, Public Law 99-509, Congressional Record, Part II, H11440-H11441, 1986.
12. English, J.T.; Kritzler, Z.A., and Scherl, D.J.: Historical Trends in Financing of Psychiatric Services, Psychiatric Annals 14:321-331, 1984

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Beyond the Cost of Health Care: The New Era of Quality and Liability in Managed Care

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In recent years, physicians, policy makers and consumers have expressed concern over the quality of care provided in managed care settings. The managed care phenomenon has been instrumental in stimulating an interest in quality, in great part due to the perceived financial incentives for health maintenance organizations (HMOs) to control the use of services in order to reduce costs. This is due to the fact that HMOs receive a fixed, annual fee and must, in turn, assure the provision of comprehensive health care services to members. In Florida, the financial and service delivery problems that plagued the Gold Plus Medicare HMO reified some of the worst fears of policymakers and health care providers.

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During the 1980s the health care delivery and financing systems converged. The result has been a mushrooming of "managed care" arrangements in the form of HMOs, preferred provider organizations (PPOs) and aggressively controlled indemnity plans. To an increasing degree, these new arrangements have combined the functions of insurance and health care delivery under the management of a single organization: HMO, PPO administrator, or third party administrator (TPA).

In this presentation, we summarize the rapidly emerging interest among providers, patients, insurers, purchasers and government in the quality of health care, especially as it relates to managed health care. We also review the recent recommendations of the State of Florida HMO Quality of Care Task Force. These recommendations served as the basis for the newly enacted HMO bill in 1987.

From cost containment to quality of care: Immediate past as prologue ● By the late 1970s and early 1980s, competition and cost containment had become the bywords of health care policy and services delivery in the U.S. Providers, third parties, individual service users, business organizations and government were afflicted with an obsession to manage costs. Physicians and hospitals found that they had to focus on costs to ensure their market shares in a rapidly changing health care economy.

Changes in public and private reimbursement systems forced providers to more effectively manage their own costs to be in a position to competitively price their products. Subsequent competition has taken the form of television commercials, billboards, mass mailings and lavish newspaper and phonebook ads. Aggressive new reimbursement guidelines and utilization review in Medicare and private insurance

plans, along with empty hospital beds, helped to stimulate this behavior.

Throughout the late 1970s and early 1980s, HMOs, PPOs and a plethora of ambulatory care delivery systems began to dot the health care horizon. Groups of physicians, entire county medical associations, and individual hospitals reluctantly, then aggressively, deployed marketing strategies. The growth of HMOs and PPOs stimulated physicians to become sensitized to concepts such as maintenance and cultivation of "market share" and in many cases HMOs were created by groups of physicians as defensive mechanisms against the market threat posed by national, "name-brand" HMOs.

Convergence of health care delivery and health insurance ● HMOs and PPOs have become major participants in the health care system. These programs have succeeded in attracting the attention of patients, physicians and hospitals because of their popularity with major purchasers, i.e., business organizations. Two of the principal, purported advantages to purchasers are reduced inpatient hospital care and a greater reliance upon primary care — ostensibly leading to reduced health care costs.[1] The modified utilization patterns that result usually involve care managed by a medical (MD or RN) or administrative gate-keeping system. Usually, the HMO or PPO arrangements include financial disincentives to the use of services outside the proscriptions of the plan.[2]

The issue of health care costs remains prominent among policymakers, purchasers and consumers. But the relative costs of competing health care "products" have, in recent years, become similar. Purchasers of health benefits plans, for example, are often confronted with a selection from a variety of HMO, PPO and indemnity options but there may be little or no difference in the prices or benefits offered. How, then, can purchasers make decisions about the "best" plan? One obvious way is to include information about relative quality in such decisions.

Back to basics: Emerging era of quality of care ● As costs become increasingly similar and a variety of health care products are offered to more sophisticated purchasers, e.g., business organizations and company coalitions, they will want to base their decisions about purchases on more than just cost information. Comparable prices will likely encourage purchasers to ask: "What are we getting for the money?" Thus, objective quality measures, coupled with information about consumer satisfaction, may become important indices of "product" superiority.

Alternative delivery systems, hybrids of profit and nonprofit ownership, various financing arrangements and stricter reimbursement systems already have had sobering effects on spiralling costs. Efforts by business organizations to exert greater management control over health benefits plans have started to include attempts to measure quality. Local business coalitions, for example, have become active proponents of prospective, concurrent and retrospective utilization review.

There may be a danger, however, in correlating utilization review with quality. Often, utilization review activities are focused on cost containment. Reducing utilization alone does not ensure higher quality it may, under some circumstances, even jeopardize it.

The Washington Business Group on Health, a nationwide coalition of major U.S. corporations, and the Group Health Association representing the nation's HMOs recently agreed to establish a standardized data base on HMO utilization and costs. Such a base would be a key step toward measuring and monitoring variations in care. The American Medical Association, Joint Commission on the Accreditation of Hospitals, and other organizations announced that they are developing new measures of quality of care that would be used for inpatient and outpatient services. The JCAH is already certifying certain measures of quality of care in HMOs using a set of criteria derived from the Health Care Financing Administration (HCFA) guidelines for HMO participation in Medicare.

Dynamics of change in health care: New roles for providers, third parties, consumers, business organizations and government.

Providers ● Organizational and financial changes in health care have caused many providers to become full-scale health services corporations. These corporations have as a goal the capture of cash flow associated with the broadest possible range of health care products. For example, corporations, both investor owned and not-for-profit, came to own hospitals, ambulatory care and surgery centers, third party administrators and insurance companies, hospital design groups health care management firms and even HMOs. The perceived need to operate more efficiently has led to this organizational style, which is known as vertical integration.[3]

Third parties ● Third party organizations including traditional insurance companies, Blue plans, and a new genre of financial service corporations, literally jumped on a cost-containment bandwagon in the late 1970s in order to ensure continued cash flow. In response to demands of corporate and government clients, third parties marketed cost control strategies consisting of more aggressive reimbursement systems. These systems boasted powerful auditing and utilization review capabilities, claim data analyses, and a spectrum of options for financing health benefits plans.

Insurance companies became especially visible proponents of cost control. Full page advertisements in the nation's leading newspapers, business and trade journals drew attention to the unique cost manage-

ment capability of each company. Minimum premium plans, per capita and aggregate stop-loss, infinite permutations of cost-sharing arrangements, flexible benefits and a seemingly endless litany of financing alternatives are still marketed as elixirs that will lead to efficient health plans.

Through all of this posturing and public relations, the corporate payor was transformed into the patient of insurance companies and benefits consultants. And the "ailment" was conveniently identified as being a sloppy and greedy health care system. Physicians and hospitals emerged as the bad guys who had to be reined in and controlled by way of aggressive claims management, prospective, concurrent and retrospective utilization review, and treatment protocols (especially in formally managed care systems.) These cost-containment marketing ploys, combined with increased malpractice litigation, ushered in what has become an open season on health care providers.

Insurance companies and third party organizations have become increasingly difficult to distinguish from health care providers. CIGNA, Prudential, Blue Cross and Metropolitan now own or manage HMOs, organize and market PPOs and offer extensive utilization review services to their clients. The major investor owned hospital corporations have purchased insurance companies, and most hospitals have developed aggressive PPO marketing strategies.

Service Users ● Individual health care consumers, traditionally the "patients,", have become more sensitized to the costs of care. This is due to several factors including increased consumer sophistication about health matters, transition into a chronic disease era, and large increases in cost sharing provisions in public and private health plans (deductibles, copayments, and share of premium dollars.) People are being required to pay more for their health care and, at the same time, they may even be realizing that they have to assume a greater degree of responsibility for managing their own lifestyles in order to reduce their risk of disease and disability.

Business Organizations ● Finally, business organizations have come to realize that they shoulder a considerable financial burden in paying for employee health services. Cost since the 1960s grew into a sizable budget item. Many companies began to recognize that health care is a commodity which they purchase as they do inventories, raw materials for production, capital assets and key employees.

Corporate purchasers have been told by their consultants that they can put hospitals out of business,[4] and that they can have a profound impact on what physicians do, the organization of health services and costs.[5]

Self-funding and self-administration of benefits plans have made it possible for most medium and large companies to manage their employee health benefits in-house without the involvement of an insurance company. Insurance companies may play a role in self-funded plans by providing "stop loss" or catastrophic insurance coverage. Self-funding has created a more direct link between purchasers and providers.

Government ● The federal government has, in many ways, led many of the formal efforts to address questions about quality of care in HMOs. The HCFA has established criteria for "federally qualifying" HMOs. The advantages to receiving federal qualification include the ability to "mandate" that employers of 25 or more offer the HMO option to employees. The federal criteria for qualification include certain financial requirements and the presence of a quality assurance program. The HCFA guidelines are not really descriptive but prescriptive, thus providing considerable latitude in interpretation.

Perhaps of greater importance is the "certification" of HMOs by HCFA as eligible to provide care under Medicare. Physicians and hospitals have benefited from the cash flow resulting from the provision of care to Medicare beneficiaries, and HMOs often seek the same opportunity. The advantages of such arrangements for HMOs can come in several forms, but most notably by way of federal HMO Medicare "risk contracts." The cash flow of an HMO from such a contract can be considerable. In the case of the IMC Gold Plus plan, about $30 million each month was paid to the plan to manage the health care of about 170,000 Medicare beneficiaries.

Under new HCFA guidelines that went into effect in early 1987, HMOs participating in Medicare as risk contractors will have to undergo increasing financial and quality assurance scrutiny, including more aggressive utilization review. The federal government is relying primarily on Professional Review Organizations (PROs) to conduct the reviews.

State governments and private certification organizations such as the Joint Commission on the Accreditation of Hospitals have developed their own standards modeled, in large part, on HCFA's Medicare HMO certification guidelines. State governments have begun to address the financial and quality assurance questions relating to HMOs. As of 1987, four states, Delaware, Indiana, Rhode Island, and Florida, defined HMOs as "providers" of care by statute. Eleven states require that HMOs purchase malpractice liability insurance as a condition of licensure. Illinois has recently put in place strict regulatory provisions for HMOs intended to provide greater assurances of financial stability and quality of care.

These quality issues become especially challenging when they concern managed care systems, such as HMOs and PPOs, because of the financial incentives to providers to operate within often strictly defined financial and utilization parameters.

Florida HMO quality of care task force findings ● Managed care settings, especially HMOs, must provide comprehensive health care services to subscribers within the limits of fixed, annual fees (premiums). Depending on the organizational structure, it is not difficult to understand how some HMOs might seek to exercise high levels of control over utilization and costs in efforts to assure profitability. Should such control result in inappropriate care, very serious questions of quality of care will be raised. In Florida, these issues have been raised by policymakers in response to a rapidly growing HMO industry and in reaction to the considerable publicity given to the IMC Gold Plus plan.

In late 1986, Florida Insurance Commissioner, Bill Gunter, formed a statewide advisory group to examine the issue of quality of care in HMOs and managed care. The HMO Quality of Care Interagency Task Force was chaired by Dr. Peter J. Levin, Dean of the University of South Florida College of Public Health, and included Commissioner Gunter and Amy Jones, Director of Licensure and Certification for the Department of Health and Rehabilitative Services. By statute HRS and DOI share regulatory purview over aspects of HMO operations.

The Task Force offered eight recommendations to the Legislature concerning the regulation of HMOs.

1. HMOs should be regulated as insurers **and** providers of health care services. Both the Department of Insurance and the Department of Health and Rehabilitative Services should continue to exercise regulatory authority over HMOs.

2. Written quality assurance guidelines and in-place quality assurance programs should be required of all HMOs doing business in Florida. Currently this is only a federal qualification requirement but the Task Force felt that documentation and an ongoing quality assurance program were fundamental.

3. Annual certification, license fees or assessments for the costs of regulation should be imposed and related to premium dollars or subscriber enrollments. Fees have been very low, state financial requirements quite modest, and individuals and corporations have been able to form HMOs for a relatively small amount of money. The costs of monitoring and regulating should be paid by the industry. For these reasons, fees should relate to number of enrollees or actual premium dollars.

4. HMOs should be required to notify the Department of Professional Regulation in all instances of disciplinary removal, suspension or resignation of licensed medical professionals. During the public hearings and research process, the Task Force determined that some HMOs frequently discontinue contractual relationships with physicians because they did not always subscribe to the HMO practice patterns or because of quality of care problems. But no reporting requirements were in place to keep track of medical professional discharges as are required in hospital settings. Since the HMO is a "provider of care," it should be subject to some of the same requirements as hospitals.

5. A standard, grievance procedure should be required of all HMOs, and the state should establish a toll-free hotline for unresolved HMO grievances. Appropriate regulatory sanctions should be put in place to ensure compliance with grievance procedures.

6. Consideration should be given to consumer participation on HMO boards or standing quality/satisfaction committees. Two categories of participation were considered by the Task Force. The first involves actual service users — patients. They should play an active role on the HMO's grievance committee and could also provide ongoing input to the board on user satisfaction. The second involves corporate purchasers of HMO services. Local employers who have large numbers of employees enrolled in a particular HMO should be encouraged to have a representative on the board.

7. Clear guidelines should be established for the marketing and sales of HMO products. Marketing and sales personnel should be regulated by licensure or bonding. During testimony and analysis of grievances, the Task Force found numerous instances of inappropriate marketing of HMO products, especially to Florida's aged population. Many elderly residents found that they had been enrolled in numerous Medicare HMOs or supplemental insurance programs without their knowledge.

In 1987 the Florida Legislature enacted a new HMO bill which included many of the Task Force's recommendations. This bill places Florida in a national leadership position in the regulation of both the quality and financial viability of HMOs.

Conclusion ● "Quality" in health care is a complex issue. In the prsent marketplace, the myriad quality questions also raise new liability issues. For example, if an HMO is a provider of care and the care given is found to be of poor quality and, as a consequence, the health of the patient is affected, then the HMO, as an entity, may be included in malpractice litigation. The same may apply to PPOs where aggressive utilization review might result in inappropriate care. The PPO administrative entity may find itself included as a party in malpractice litigation as a result of having poorly managed the patient's care.

Quality cannot be defined in simple terms, nor can it be regulated without the active input and involvement of physicians, service consumers, purchasers of group benefits and objective researchers. In today's health care arena, state regulatory agencies should be bound by the imperatives of public policy to put in place demanding standards and guidelines

for health maintenance organizations and other managed care programs doing business in the state.

References

1. Luft, H S.: How Do Health Maintenance Organizations Achieve Their Savings? N Engl. J. Med. 298, no. 24, p. 136.
2. Wolfson, J. and Levin, P J.. Managing Employee Health Benefits: Guide to Cost Control, Homewood, Il., Dow Jones - Irwin, 1985, p. 122.
3. Goldsmith, J.: Can Hospital Survive? Homewood, Il., Dow Jones-Irwin, 1982.
4. McClure, W National Conference on Data Use in Health Care, Sponsored by the Washington Business Group on Health, Miami, January 1986
5. Rufilson, R. National Conference on Dade Use In Health Care, Sponsored by the Washington Business Group on Health, Miami, January 1986.

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Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712 Issued 3/84

References:
1. Grossman MI: *Scand J Gastroenterol* 58 (suppl 15):7-16, 1980.
2. Marks IN, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly* Edinburgh, Churchill Livingstone, 70-81, 1984.
3. Krentz K, Jablonowski H, in Hellemans J, Vantrappen G (eds): *Gastrointestinal Tract Disorders in the Elderly* Edinburgh, Churchill Livingstone, 62-69, 1984

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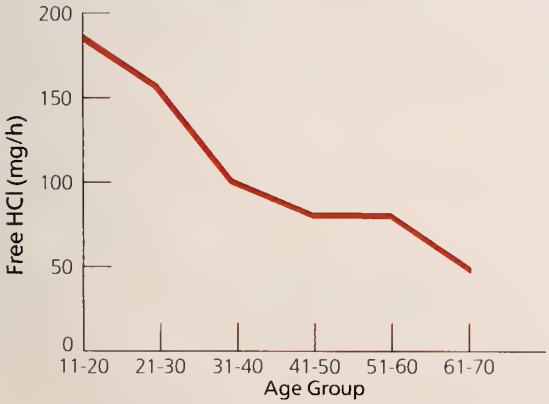

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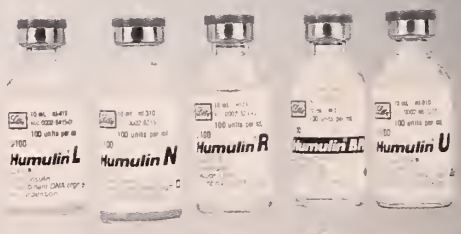

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The Delusion of Government Price Control as an Effective Mechanism for Medical Care Cost Containment

Health care providers labor under a mounting snowfall of administrative restraint. The untested hypothesis, of course, is that this layering of governmental regulation upon providers will somehow dampen the updraft in medical care costs. The data, from here and abroad, suggest the opposite: that government interference might be accelerating rather than containing health care expenditures.

The two-decade span from 1960 to 1980 was accompanied by a general inflation — not just in health care costs but in the economy as a whole. Health care consumption and total costs increased but there remained a close relationship between the two rates of inflation. By 1979, the rise in health care costs was exceeding that in the remainder of the economy by about 0.9% a year — a paltry difference considering the passage of multiple health care entitlement programs by the government, the enhanced intensity of health care needed by an aging population and by the expensive technology that was being created (Fig. 1).

The close parallelism between health care and general economic inflation diverged in 1982 when a broad gap appeared between the rise in health care expenditures and that for the economy as a whole for the first time. Inflation in the general economy was being subdued by the 1981-1982 recession. Traditionally, changes in the economics of health care lag behind those in the general population by 12-24 months. This initial disparity between the rates of general inflation and medical inflation has been ascribed to this delay in the response of the health care sector to changes in the general economy. In 1984 and 1985 the difference between the two inflation rates narrowed but the differences remained far broader than those that had been observed during the 1960s and 1970s. Since 1985 the situation has deteriorated; the medical inflation rate has far exceeded the general inflation rate. In 1986 the general inflation rate was 1.9% while that for medicine was 7.5% — nearly four times greater.[6] The irony is that the disruption of the close relationship between general and medical inflation occurred during a period when the federal government, the states, and to a lesser extent, industry, were attempting to control medical expenditures by the imposition of severe limitations on hospital and physician reimbursement.

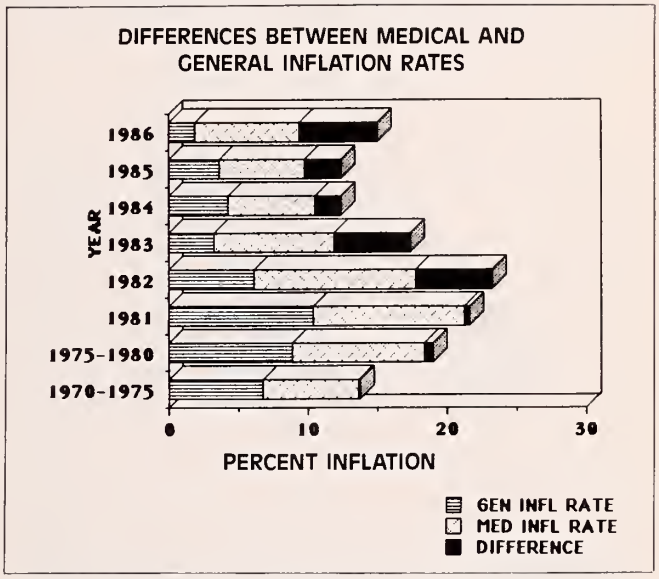

Fig. 1.—The difference between the inflation rates of all prices in the general American economy and those related to health care from 1970 through 1986. Note that the years from 1970 to 1975 and 1975 to 1980 are five year averages. The general inflation rate has always been less than the medical inflation rate. In 1986 the differences between the general and medical inflation rates broadened to the largest differential of the past two decades.

Figure 2 shows the inflation rates that have prevailed in the costs for medical care for the past 30 years, as related in terms of percent increase in the per capita health care cost. The rates steadily increased until 1981, then fell through 1985 but have been creeping upwards since then.

Hospitalization rates have also started to ascend. From 1981 to 1983 the total number of inpatient hospital days declined for both the aged and the under age 65 populations. This decline stopped and reversed in 1986.[6] The total number of hospital days has begun to rise again, despite the efforts of the Heath Care Financing Administration, HMOs and PPOs to severely restrict hospitalization by the application of restrictive admissions criteria and duration of stay policies.

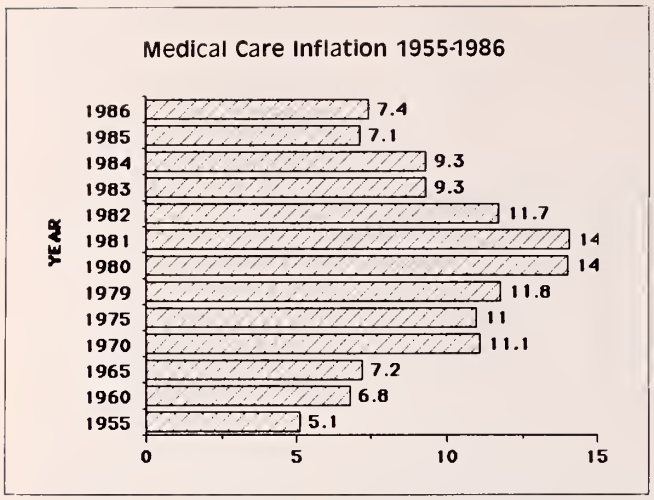

Fig. 2.—Medical care inflation in the United States between 1955 and 1986. Note that the periods from 1955-1975 are represented as five year averages.

The current government-induced controls over the medical marketplace are not working; they may result in the opposite effect and exaggerate the ultimate costs of medical care in this country. Thousands of years of economic history attest to the futility of employing wage and price controls as tools for containing inflation.[3] Modern history is no exception. In 1971 the Nixon administration attempted to subdue the Viet Nam war inflation by wage and price controls but managed only to create shortages, black markets, unemployment and to unleash a post-control inflationary binge that did not end until 1982. The European governments of the 1970s also tried wage and price controls to curb their inflation but similarly experienced a ricochet effect on their inflation rates; these exceeded 15-20% in many countries by 1980.

Wage and price controls have not worked as a means of controlling inflation in the general economy of Western industrialized nations. What is the experience of greater government regulation in controlling health care costs? An economic x-ray of this issue can be obtained by examining two related issues: 1. the inflation rate of health care costs in other countries which have socialized medical care systems; and 2. the effectiveness of hospital rate control programs that have been imposed by some states in this country during the past ten years.

The current government-induced controls over the medical marketplace are not working; they may result in the opposite effect and exaggerate the ultimate costs of medical care in this country.

Figure 3 demonstrates clearly that the increase in health care costs that the United States has experienced during the past 30 years is not an American phenomenon; it cannot be attributed to our fee-for-service, market-driven health care system. Inflation in health care costs has been seen in all the industrialized nations of the West. Since the economic vitality and the inflation rate of the countries represented are so different, a fair means of examining the increase in expenditures for health care can be obtained by relating these costs to the gross national product (GNP) of each country. In 1980, the year for which the most recent comparable figures are available, Sweden and West Germany used 9.7% and 9.6%, respectively, of their GNP for medical services. The USA used 9.4% while France and Netherlands each used 8.9%. Canada and Great Britain dedicated a significantly smaller share of their GNP to medical services — 7.4 and 5.8% each.[2]

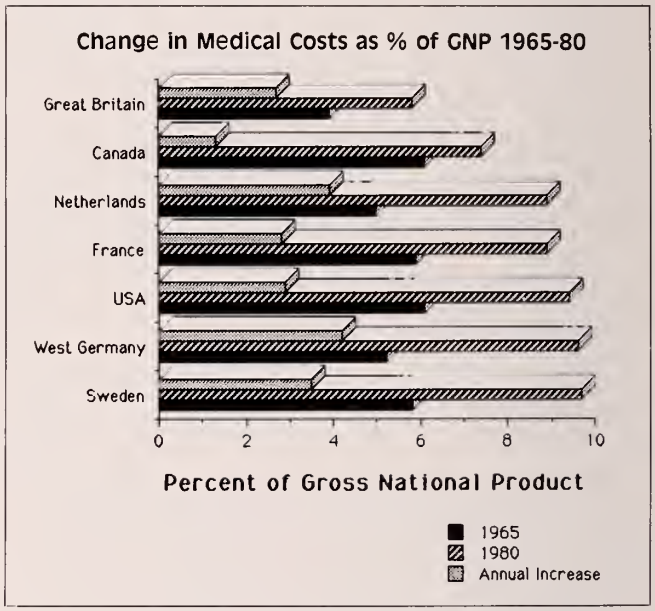

Fig. 3.— Comparison of the escalation in medical care costs among selected Western industrialized nations. Health care expenditures are expressed as a percentage of the gross national product of each nation for the years 1965 and 1980. The average annual increase in the percentage of the GNP that occurred between 1965 and 1980 is represented as the "annual increase."

Figure 3 also illustrates the *change* in the fraction of the GNP of these countries that has been devoted to health care between 1965 and 1980. In 1965, medical care required 5.8% of Sweden's GNP but 9.7% of its GNP in 1980. The compounded *rate of increase in the fraction* of GNP spent for health care was 3.5% for Sweden during that fifteen year period. The rates for West Germany, the USA, France, the Netherlands, Canada and the United Kingdom were 4.2, 2.9, 2.8, 3.9, 1.3, and 2.7, respectively. Thus, the United States, which had enjoyed a relatively unregulated form of health care during the 1965-1980 period, expended the same proportion of its national wealth to health care as did countries with highly regulated, and socialized systems. Government control does not curb health care expenditures.

As nations become wealthier, that is, as their GNP per capita increases, the citizenry will seek more health care. This phenomenon has pervaded all the Western countries during the past fifty years. The economy that more exhuberantly enhances personal wealth will promote a greater consumption of health care. During the past twenty years the United States and West Germany have outstripped all other Western nations in increasing real (after inflation) personal wealth. Their consumption of health care has also increased the most. Morbid economies, such as those of Canada and Great Britain, have not witnessed such an increase in health care expenditures. Individuals with more expendable income are willing to seek out

Is it possible that one of the causes of the economic depletion of Canada and Great Britain is their lack of commitment to a better quality of medical care?

and pay for a better grade of health care in the same fashion as they will buy a better car or a bigger home. Health care is a manifestation of the nation's personal wealth.

A correlative issue is whether an increased contribution in the proportion of a nation's income to the health care of its citizens will, in itself, increase the nation's wealth. A more technologically complex and personally intense health care system requires more personnel to provide direct care of the patients as well as to service the technical, administrative and informational facets of medical care. These requirements create more jobs, more disposable household income, and more wealth that can be spent in other sectors of the economy. Furthermore, as the nation has committed a greater portion of its annual income to health care, its losses incurred by the cost of illness have fallen. The cost of illness has two components: the cost of medical care and the cost of lost productivity of the sick individual. The cost of illness in terms of loss of income from premature death, disability or retirement, has receded dramatically during this century. The increased economic productivity from sick individuals who have been returned to gainful employment adds to the gross national product of the nation and to the wealth of the populace as a whole. These wealth-enhancing aspects of medical care need to be examined more fully before legislators and others who wield decision-making powers destroy a potent wealth building tool — namely the medical care system that has evolved in the United States. Is it possible that one of the causes of the economic depletion of Canada and Great Britain is their lack of commitment to a better quality of medical care?

The experience with regulation of hospital charges by states is a second piece of evidence that government fiat is a flimsy tool for pounding down health care costs.[5] Six states (New York, Massachusetts, Connecticut, New Jersey, Maryland and Washington) have imposed regulations on hospital charges over the past ten years. From 1976 to 1983 the regulated states experienced an annual percentage growth in per capita hospital expenditures of 12.2%. This figure did not vary signficantly with the mean increase of 14% that occurred throughout the entire nation during the same period. However from 1983 to 1985 the regulated states suffered a mean increase in their per annual capita cost of hospitalization of 6.92% versus a national increase of 4.8%. Three of four worst performers in the 1983-1985 period were regulated states: Washington, New York, and New Jersey (Fig. 4). Thus regulation of hospital rates has not made a significant difference in the per capita costs of hospitalization.

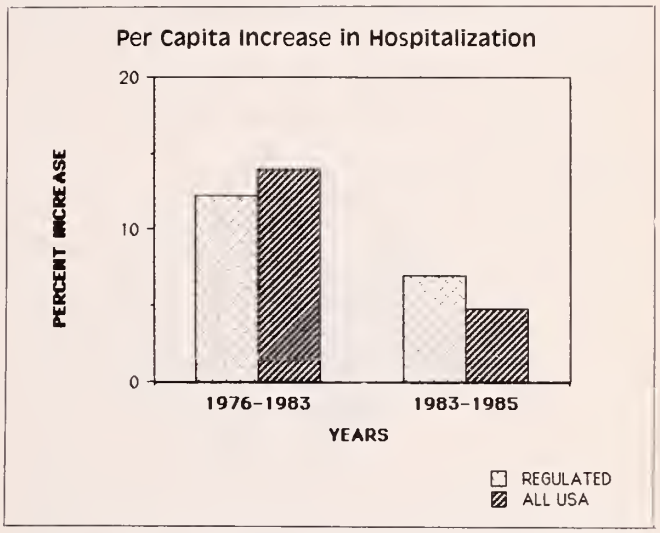

Fig. 4.—Per capita increase in the annual costs of hospitalization within the entire United States as compared to the annual increase in those states with hospital rate setting controls, 1976-1985.

It has been argued that regulation of hospital costs has several adverse effects on the overall economies of hospital care. Innovative cost-saving producers will be discouraged from entering states in which prices are controlled. Lack of new competition discourages inefficient hospital providers from leaving the state. Thirdly, health care resources that might be saved as a result of limiting inpatient services will be expended in other settings — such as the outpatient departments. No real savings accrues to society. Gamesmanship, based on regulatory dictates rather than cost efficiency, drives any government-controlled system. This impedes the evolution of competition-inspired efficiencies.

The attempt to further limit hospitalization by either restricting admissions or by reducing the length of stay of patients has little chance of significantly altering total national health care costs. The average length of a hospital stay in the United States already is much lower than that of all other industrial nations;

the number of admissions to the hospital per capita has been rising for the past two years despite the heroic efforts to delimit this figure.

Administrative efforts to slow health care expenditure have been aimed at hospitals and at physicians. Yet these two components of the health care budget constitute just 59% of the health care dollar (Fig. 5). Inflationary pressures were intense in the remaining areas of health care: nursing home care, home health care, other professional services such as physical therapy, dental services, medications, eyeglasses, and other medical commodities increased between 9 and 10% between 1985 and 1986.[6] Expenditures for biomedical research, new facility construction and overhead administrative expenses for government and private insurance programs rose less than 4% from 1985 to 1986 — an amount still higher than the rate of inflation for other goods and services in the general economy.

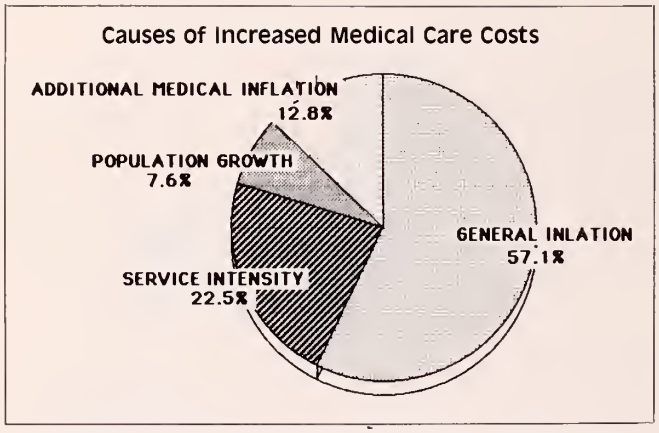

Fig. 5.—Causes of increased medical care costs in the United States between 1973 and 1983.

The medical price inflation that occurred between 1973 and 1983 in the United States can be attributed to several factors (Fig. 6). General inflation in the economy accounted for 57.1%. An increase in the intensity of services (which refers to greater use of high technological diagnostic or therapeutic procedures per patient) caused 22.5%. Population growth accounted for 7.5%. Actual inflation in terms of price increases by health care providers (mostly hospitals) contributed 12.8%. Physician avarice did not cause significant price increases. The average physician lost nearly 5% of his or her net, disposable income during the 1975-1985 decade.[4] Family practitioners, pediatricians, and internists lost 15-17% of their net income in this period.

The recently released study, Price Controls for Medical Services and the Medical Needs of the Nation's Elderly,[3] has advised us that the increase in medical care prices has a technological basis and is not due to the marketing power or greed of physicians and other health care providers. It further warns us that price controls, such as mandatory Medicare assignment, fee restriction, and the like, will entail

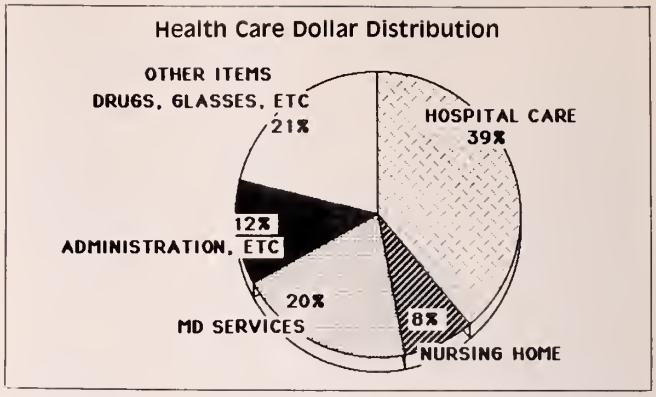

Fig. 6.—The division of spending of the health care dollar in the United States, 1986.

social costs that will prove detrimental to the elderly or other groups of people that such controls are intended to benefit. Controls will ultimately reduce both the quality and the quantity of care that is rendered to the patients. Furthermore, reducing fees below a certain market level may have an adverse effect on the Medicare budget; the study predicted that such a fee cap will immediately lead to greater amounts of medical service consumption and an actual increase in the government's Medicare outlay.

In summary, the legislator or administrator who advocates further cost control measures for American medicine is afflicted with mythopoeic delusion or guilty of babbling flatulent gibberish. The history of price controls as an effective means of altering socioeconomic structures in a positive way is dismal. The experience of government control of the health care systems in either the United States or other industrialized Western societies has failed to stifle the increase in health care consumption. The recent appearance of an increased differential between general economic inflation and the inflation in medical care costs may be an early warning sign that government interference is already causing distortions and dislocations in the economics of American medicine. All of us would like to see the rise in the cost of medical care abate. However, price controls are a form of remedy in which the pain from the toxic after-effects exceeds any benefit they may provide to society.

Bibliography

1. Anderson, G.F.: National Medical Care Spending, Health Affairs, Fall 1985.100-107.
2. Arnett, R.H.; Cowell, C.S.; Davidoff, L.M., and Freeland, M.S.: Health Spending Trends in the 1980s: Adjusting to Financial Incentives, Health Care Financing Review, Spring 1985:1-24.
3. Baumol, W.J.: Price Controls for Medical Services and the Medical Needs of the Nation's Elderly. Department of Socioeconomic Research Information. American Medical Association, Chicago 1988.
4. Clare, F.L., Spratley, E., Schwab, P., and Inglehart, J.K.: Trends in Health Personnel, Health Affairs, Winter 1987:90-195.
5. Finkler, M.D.: State Rate Setting Revisited, Health Affairs, Winter 1987: 82-89.
6. Pearson, C.: National Health Expenditures, 1986-2000. Health Care Financing Review, Summer 1987.1-36.

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NOTES & NEWS

AMA Offers New Member Benefit Packages

To enhance the value of membership, the American Medical Association will offer members an opportunity to select one of three new benefit packages in 1988. Members will have the opportunity to select one when they receive their 1988 Membership Kit.

Members should watch their mail for the Kit, which includes a certificate suitable for framing, a wallet-sized card, and a flyer describing the complete array of products and services to which members are entitled. In addition, the Kit includes a postage-paid business reply card which members should use to select one of three new benefit packages of comparable worth and return the card to the AMA. Members will receive their package as it becomes available.

The new benefit packages are the first in a series of steps in a major new AMA program which addresses the differing membership needs of the various segments of the medical profession. This program, which will become fully operational by the end of 1988, was developed with the MAC Group, a Cambridge, MA-based consulting firm specializing in marketing strategy. The program classifies members into one of three market segments. One segment primarily seeks broad representation from the AMA. A second segment looks to the AMA first and foremost for economic repesentation. A third segment has a principal interest in receiving medical education and information from the Association. The new packages will allow AMA members to choose from three "product lines" which correspond to the three major benefit types for the first time. As a result, members will have the opportunity to self-select a tailored membership benefit package which corresponds to the market segment which most closely meet their needs.

According to James H. Sammons, M.D., "There have always been very compelling reasons for physicians and medical students to support the AMA through membership. The three new tailored benefits packages constitute yet another good reason to join. They are first steps in a continuing AMA effort to be even more aware of what members want and, more importantly, to give it to them."

Standards to Reduce Risk to Hospital Patients

The Joint Commission on Accreditation of Healthcare Organizations has adopted new standards that require hospital medical staffs to participate in the clinical aspects of risk management activities. In addition, physicians seeking medical staff membership or renewal of clinical privileges are required to disclose any disciplinary actions that may have been taken against them, as well as any adverse judgments or settlements in medical malpractice actions.

The prevention-oriented standards, which go into effect January 1, 1989, require medical staffs to become involved in:

- developing criteria for identifying specific cases with potential risk in clinical aspects of care;
- correcting problems in clinical care uncovered by risk management activities; and
- designing programs to reduce risk in the clinical areas of patient care and safety.

The new standards call for a flow of information from the risk management to the quality assurance function in a hospital and for governing body support of risk management activities relating to patient care and safety.

Information to be provided in physicians' applications for staff membership or clinical privileges must include pending challenges to and/or loss of any licensure or registration, as well as voluntary or involuntary termination of medical staff membership or loss or reduction of privileges at another hospital. Reporting adverse final judgments or settlements in malpractice actions to the hospital is a minimum requirement. Any additional requirements for disclosure of further information regarding a practitioner's involvement in litigation must be specified in the hospital's medical staff bylaws.

"By working together under the standards' guidelines, hospital management and the medical staff can use information about risks to patients to improve the quality of care," said William Jessee, M.D., Joint Commission vice president for education.

The Joint Commission is considering similar standards for nursing homes, mental health centers, home care organizations, ambulatory care organizations, and hospices.

List of Registered Dieticians Available

The Consulting Nutritionists in Private Practice, a practice group of the American Dietetic Association, has compiled lists for all states of their members in private practice. Registered Dietitians (R.D.) are recognized by the medical community as the legitimate provider of nutrition care. To receive a free list for your state, send a business-sized, self-addressed, stamped envelop to: Consulting Nutritionists, 9212 Delphi Rd. S.W., Olympia, WA 98502.

Also available is a list of nutrition resources produced independently by members of Consulting Nutritionists. Please specify if you would like a copy of this resource list.

Consulting Nutritionists provide nutrition counseling, wellness programs and nutrition program development in the community. Nutrition counseling by dieticians can be tailored to individual needs for a variety of conditions, including: allergies, cancer, diabetes, hypertension, hypoglycemia, heart disease, malnutrition, obesity, pregnancy and lactation and other conditions that warrant nutrition intervention.

1988 ASCP Medical Photography Contest

Healthcare professionals who are interested in medical photography are invited to enter the annual American Society of Clinical Pathologists Medical Photography Competition, sponsored by Nikon, Inc. Up to three entries may be submitted in each of three categories: gross or macroscopic; microscopic; and electron microscopic.

The purpose of the Competition is to encourage and recognize excellence in the field of medical photography. Each entry will be judged on its scientific merit, content, composition, quality of image, and originality. Last year, nearly 400 entries were submitted.

The following cash prizes will be awarded in each of the three categories: 1st prize — $500; 2nd prize — $300; 3rd prize — $150; and two honorable mention awards — $50 each. Certificates of merit will be awarded to all entries that meet a minimum standard of photographic excellence.

Winning entries will be displayed at the 1988 ASCP/CAP Fall Meeting in Las Vegas, Nevada, and will be published in the official ASCP journal, *Laboratory Medicine*.

The ASCP and Nikon, Inc., will sponsor, judge, and produce the 1988 Medical Photography Competition. Entries must be submitted no later than June 1, 1988. Official entry forms are available from the ASCP, 2100 W. Harrison St., Chicago, IL 60612, Attn: Medical Photography Competition, or toll-free 1-800-621-4142.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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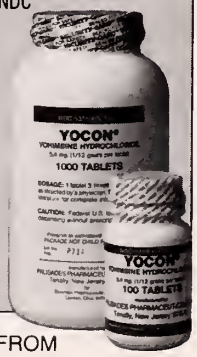

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During the past two-and-a-half years, the University of Miami School of Medicine's biomedical research program has experienced unprecedented growth in both basic and clinical activities. During the fiscal year that ended last May, $58 million was awarded for research. The basic sciences alone (immunology, cell biology, biochemistry, pharmacology and molecular biology) have added over $6 million per year in new funding during the past three years.

This represents a 30% annual rate of increase, with monies from the National Institutes of Health and other federal agencies accounting for well over half of those dollars. Other funding sources — private, state and industry — have also increased dramatically. Projections indicate that these figures will continue to grow in the coming years. More than 430 new clinical and basic science faculty have been appointed in just a little over four years, adding vitality to our investigative activities. This funding picture is especially important because it constitutes a testimonial to the effective competitiveness of our scientists at a time of reduced or level funding nationwide.

The logarithmic growth of research has occurred primarily in the major areas of concern to the practice of medicine in South Florida. The bulk of increased funding has gone to AIDS, cancer, neurological disorders of aging and diabetes. By mid-year 1988 we expect our sponsored program activity to exceed an annual level of $75 million, impacting on the economy of South Florida through the multiplier effect of grant money in use of products and services. More importantly, however, this research growth produces new knowledge, leads to new clinical applications and supports the School of Medicine's teaching effort.

We are particularly pleased that the success of the research program has blossomed at a time when our primary teaching hospital, Jackson Memorial, has been cited as one of the top hospitals in the nation by two sources, The Best in Medicine (Harmony Books 1986) and The Best Hospitals in America (Henry Holt & Company 1987). This combination of an excellent educational program, as characterized by the Liaison Committee on Medical Education, the ability to create new scientific knowledge through research and an excellent health care center will continue to have a far-reaching effect on our advancing quality medical care locally, statewide and nationally.

Robert Rubin, Ph.D.
Deputy Dean for Research & Graduate Studies
University of Miami School of Medicine

Bernard J. Fogel, M.D.
V.P. for Medical Affairs and Dean
University of Miami School of Medicine

Is It Time to Abolish The Contingency Fee?

"I have a totally clear conscience about it. I make a great living suing doctors." — J.B. Spence, *Florida Trend*, Dec., 1987.

The slogan of the Department of Commerce Division of Tourism here in Florida could be applied to our Medico-Legal system in this country. Physicians faced with an increasingly oppressive and seemingly unfair liability situation wonder what makes our legal system different and how did it grow to become so unbalanced?

Japan, India, Canada, England, France and Germany have outlawed the contingent legal fee and it is no coincidence that the professional liability insurance rates for physicians in those countries are a fraction of the rate paid by U.S. physicians.

The English view is that litigation is a social ill and one who stimulates or assists lawsuits to which he is not a party is dealt with as a troublemaker (the basis for the crime of barratry).

If our American legal system developed directly out of the English Common Law, how did we diverge to a system in which litigation is considered a socially useful way to resolve disputes and the contingent fee in legal disputes has become the prevailing method of attorney payment for tort actions, regardless of the ability of the plaintiff to pay? In this bicentennial celebration and constitutional reexamination time, perhaps an exploration of the historical context here may shed some light on what changes are necessary to meet the common good of society.

In England, the role of advocate, presenting a client's case in court, is limited to a subgroup in the legal profession, called *Barristers. Solicitors*, or attorneys, carry out other legal functions but do not represent clients in court or otherwise act as advocates. It was establish early in Greek, Roman, French and English law that the advocate would not be paid for this service, except by honorarium. Payment is now expected, but suit for payment of fee is unethical.

The barrister is to be insulated from direct dealings with the client, and the fee is sent without regard to the outcome of the proceedings. The barrister later looks to the solicitor for payment of the previously-determined fee at the completion of litigation. The fees of the solicitor are regulated in great detail, and contingent fees for payment of services of either barristers or solicitors are illegal.

Apparently, during the formative period of the American legal profession, the frontier spirit of antiprofessionalism flourished and there was general suspicion of some of the aristocratic English ways. Law practice was equated with a trade and the economic relations with clients were those of the open market, without regulation.

Contingent fees in this country evolved gradually in all states as a means of financing the legal needs of working-class persons with job-related injuries who could not otherwise afford legal representation. America had a written constitution and bill of rights, in contrast to England, and citizens had "inalienable rights" which were enforceable. Any thought of a *right* being available only to those with wealth was repugnant. Thus we evolved in the United States from a system in which contingent fees were condemned as promoting litigation purely for private profit, to nearly universal use of the contingency fee to finance tort litigation. This is a uniquely American development which is considered contrary to the public interest, unprofessional, and illegal in England, France, Germany, Japan, and most other countries.

Fundamental to the concept of the contingency fee in litigation is the concept of risk-taking by the attorney. The fee awarded to the winning party is designed to be larger than the just compensation for the amount of service in that instance because no payment will be received in losing cases. In England, the losing party is assessed for the prevailing party's legal expenses. The so-called *American Rule* developed that each party to the litigation would pay his own attorney.

The arguments against contingency fees in this country are many: that they result in too much litigation, clogged courts, solicitation of clients, occasional conflict between the interest of the attorney and those of the client, and so on. These arguments are usually answered with the perfect response: there are regulations in effect within the bar to address such abuses by attorneys and we have no better way to finance the legal battles of those among us who cannot otherwise afford representation.

Apparently in anticipation of criticism of the contingency fee system, the Florida Bar recently voluntarily proposed limits on such fees.

1. Without prior court approval as specified below, any contingent fee which exceeds the following standards shall be presumed, unless rebutted, to be clearly excessive:

i. 33½% of any recovery up to $1 million through the time of filing of an answer or the demand for appointment of arbitrators;

ii. 40% of any recovery up to $1 million through the trial of the case;

iii. 30% of any recovery between $1 and $2 million;

iv. 20% of any recovery in excess of $2 million;

v. If all defendants admit liability at the time of filing their initial answers and request a trial only on damages:

A. 33½% of any recovery up to $1 million through trial;

B. 20% of any recovery between $1 and $2 million;

C. 15% of any recovery in excess of $2 million;

vi. An additional 5% of any recovery after notice of appeal is filed or post-judgement relief or action is required for recovery on the judgement.

At some point, when the net social good of a practice is exceeded by its harm to society, change becomes necessary. The trial bar will resist any further limitations on their contingency fee system for obvious reasons. They presumably will argue that plaintiffs will lose access to the court system as they complained when the no-fault auto insurance system was instituted. However, given the number of attorneys in practice today, it does not seem likely that legitimate plaintiffs would be unable to find representation if much more stringent limits were placed upon these fees.

On the other hand, continuation of the present system is likely to produce widespread chaos in our medical care system, as high-risk procedures such as obstetrical services, neurosurgical and other emergency care become unavailable, and physicians practice without insurance or leave the state.

Many other negatives stem from this excessive concern with liability and litigation in our country. Restaurant owners, small trucking firms, and taxi drivers are seriously affected, as are all owners and managers of playground equipment, recreational facilities such as skating rinks and ski lifts, and so on. American products become even less competitive on world markets due to liability costs. College and professional school instructors are afraid to fail their worst students, and an honest letter of recommendation for an employee becomes a thing of the past because of fear of reprisals. This all amounts to an unreasonable liability burden on all of American society.

Dr. Alfred B. Swanson, an orthopedic surgeon in Grand Rapids, Michigan, led a drive for strict limits on contingency fees *as a constitutional amendment* in that state. Basically, his proposal was to limit legal compensation to one third of an award up to the first $200,000 recovered, and 5% of any amount above $200,000. Such a move enjoyed considerable citizen, as well as broad-spectrum business support, but was not officially supported by organized medicine in Michigan and failed in its petition drive by a few thousand signatures.

Dr. Swanson, in correspondence regarding our liability crisis here, has strongly recommended that we attempt a similar ballot initiative here in Florida in addition to the current drive to limit noneconomic damages through constitutional amendment. He predicts that limits on contingency fees would have strong support from the general public. Perhaps we should consider such a move in Florida as a way to achieve meaningful tort reform.

Thus, while it would be futile to dream of a life in America without contingency fees fueling deep-pocket litigation, it may not be futile to work for the restoration of sanity in our legal system. Fair limits on contingency fees would go far to strike a better balance between reasonable compensation for injured parties and the productivity of the society in which they live.

Ray Bellamy, M.D.
Tallahassee

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Mandatory Assignment: Stealing Time and Quality

The prospect of mandatory Medicare assignment presents me with a great personal dilemma as a conscientious physician. By nature, I must do well whatever I do. I went back to school to become a physician after 10 years as a laboratory scientist because I was interested in people and their problems. I am interested in each of my patients as an individual human being. I listen to them carefully. I give them time to grope for, and find, what they *really* want to say.

I ask probing questions and wait patiently for the answers. Or draw them out. I don't cut my patients off in mid-sentence. I know that what they have to tell me is important. I listen. I get to know them. It takes time.

But it is productive time. It is often when my patients are relaxed and have worked their way through to what they really mean that I get the clue that leads me to a correct diagnosis.

I try to educate my patients. I explain their illnesses to them in words they can understand. I tell them why it is important to do what I recommend or take prescribed medications. I tell them what side effects could occur and how to recognize them.

If patients are reluctant to do something that I know they should do, I explain the reasons why they should do so and try to talk them into it. It takes time. But it's time well spent. Only yesterday, I spent 15 minutes urging, cajoling and convincing a Medicare patient that she should have a mammogram. For years, she had refused. This time, she consented. The mammogram showed an occult carcinoma. Without the mammogram, the cancer might have gone undetected until it was too late for effective treatment. This one was caught at an early stage. There is a chance of cure. This woman's life may be prolonged, and her remaining life will probably be more vigorous and free of pain than might otherwise have been the case.

Making the time ● It takes time to be a good doctor. I am usually thinking about some patient's problems as I drink my coffee at 5:30 a.m. I normally see my last patient about 6:00 p.m., deal with telephone calls and paperwork (mostly Medicare-related) and finally leave the office about 8:00 p.m.

I am usually on call 24 hours a day. I am often awakened to attend to a patient in the hospital emergency room in the middle of the night; on the average, that takes about three hours. I may or may not get back to bed. Whatever the case, hospital and office patients, already scheduled, must be seen come the normal "working day." Twice each month, I have the weekend afternoons "free" after morning hospital rounds; but at least one afternoon on each of those weekends is usually spent in the office — catching up on Medicare paperwork. One weekend per month, I am on call for my patients and for the patients of three other doctors at all hours of the day. I am totally free one weekend per month — my only interrupted time for family activities and personal chores.

Being a good doctor takes time. Time to develop empathy. Time for analysis and concentration. My ability to serve my patients well depends upon my ability to spend time with them. And to have time to think critically about their problems.

My dilemma is that under mandatory Medicare assignment I — and, most important, my patients — will lose the luxury of time.

The mathematics of care ● Medicare will pay me $50 for doing a thorough medical examination, no more. Normally my exam takes about an hour, not because I cannot work faster — I can — but because that is how long it takes me to review carefully with an elderly person all of his or her medications, recent medical complaints or problems, review the systems of the body that might be troubling the person, discuss the need for immunizations, problems with diet and weight control, drug and alcohol use/abuse, insomnia and living situations that adversely affect health. This takes at least an hour, sometimes a great deal more, since Medicare patients often have multiple complex problems.

Yet, my office overhead averages about $60 per hour, approximately $65,000 annually (which is near the national average for internists). The office isn't fancy — just decent enough for patients to feel comfortable there and safe enough to satisfy my husband. My helpers, both mothers who work part-time, are not overpaid.

Most of my patients are elderly and therefore on Medicare. If I am forced to take Medicare assignment on all of them, I will have to make difficult choices: I can quit medicine. Or I can continue operating as I do now and be forced out of business by economic reality. Or I can see more patients and reduce the amount of time spent with each.

Cause and Effect ● Reducing the time spent with patients means reducing the quality of care. It means being brusque and hurried and moving patients along before they can say what they really want to say — and missing important clues to their illnesses as a result. It means no cajoling and urging: if I tell a woman that she needs a baseline mammogram and she refuses, I will just have to make a note in her record (for medicolegal reasons) and move along. No time for explanations. No time for education.

My dilemma is that I don't want to practice assembly-line medicine. And I don't know whether I can.

Annemarie S. Welch, M.D.
New Britian, Conn.

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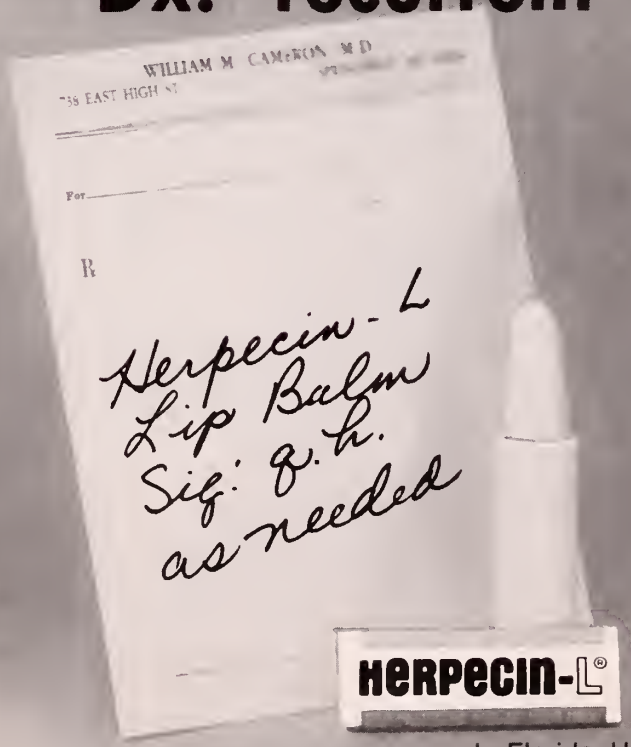

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Audio	12	19.94	9.97
Automobile	12	18.00	9.00
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Baseball Digest	12	14.95	9.97
Basketball Digest	8	9.95	7.95
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*CHILDREN:6 iss/18 months		11.97	6.00
Childrens Dig:age 7-11	8	11.95	9.97
*Colonial Homes	6	14.97	9.97
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LIFE	12	31.95	16.25
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*Mademoiselle	12	15.00	12.00
McCalls	12	12.95	7.95
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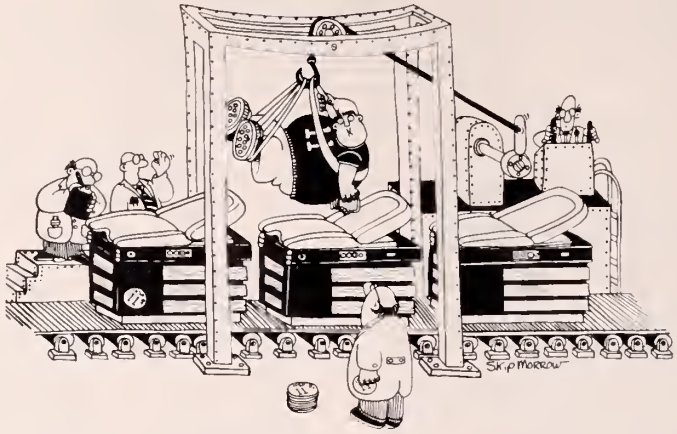

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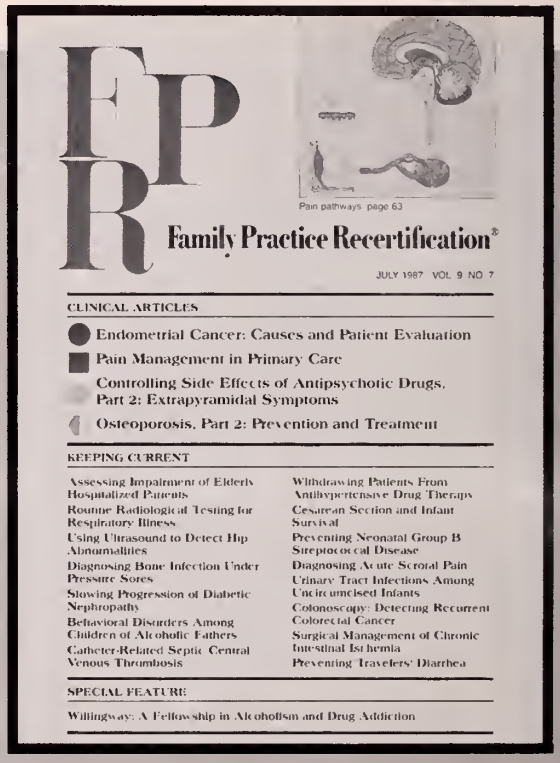

FPR

Pain pathways page 63

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JULY 1987 VOL 9 NO 7

CLINICAL ARTICLES

- Endometrial Cancer: Causes and Patient Evaluation
- Pain Management in Primary Care
- Controlling Side Effects of Antipsychotic Drugs, Part 2: Extrapyramidal Symptoms
- Osteoporosis, Part 2: Prevention and Treatment

KEEPING CURRENT

Assessing Impairment of Elderly Hospitalized Patients
Routine Radiological Testing for Respiratory Illness
Using Ultrasound to Detect Hip Abnormalities
Diagnosing Bone Infection Under Pressure Sores
Slowing Progression of Diabetic Nephropathy
Behavioral Disorders Among Children of Alcoholic Fathers
Catheter-Related Septic Central Venous Thrombosis
Withdrawing Patients From Antihypertensive Drug Therapy
Cesarean Section and Infant Survival
Preventing Neonatal Group B Streptococcal Disease
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SPECIAL FEATURE

Willingway: A Fellowship in Alcoholism and Drug Addiction

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PRACTICAL ▪ CLINICAL ▪ EDUCATIONAL ▪ CURRENT

Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

Marriage, Family, Malpractice

Many articles have been written and many speeches given concerning "stress in the medical marriage" and "stress during a malpractice trial."

Making a marriage successful is hard work. Human nature tends to tell us that marriage is full of some degree of magic. As the spouse of a medical student, intern, resident or practicing physician, you begin wondering why some of these magical qualities are already beginning to vanish.

The physician is faced with the demands of the patient, i.e, society, to be perfect. Medicine is held to a standard to which no one else has to abide; nothing less than perfect is acceptable. The physician feels the need to be omnipotent but this may also lead to the feeling of helplessness. Many physicians dreamed of being doctors for a very long period of time. It has always been a very secure profession, one held in high esteem.

Previous to living in such a litigious society, a physician primarily had to deal with the inescapable burden of responsibility for life and death. Now the constant threat of a medical malpractice suit is foremost in his or her thoughts. The total practice of medicine has changed dramatically. To help the physician guard against the potential suits, many more tests are performed.

Going through a malpractice suit has been described as being in the "Pressure Pot." This experience begins for the physician, spouse and family with the many hours spent prior to the trial preparing the case with attorneys. Since some trials last three weeks or longer, the physician has to organize the practice for coverage of patients' needs. Though it makes for an additional burden on the family, it is naturally extremely important that the physician have the utmost and constant support of the spouse throughout this grueling ordeal. This makes for a double whammy burden on the children, being without both parents for this extended time. In some instances, the children have not seen either parent for the entire period except for a fleeting moment in the early morning.

Is it any wonder that many children of physicinas have no interest in pursuing a medical career? Today children want to be in control of their time. They want to have their families experience a real family vacation, not one where Dad or Mom drops by or never makes it at all. They are keen observers of the unbearable stress and fear under which their physician parent lives. They understand that because a suit is filed it does not mean there is negligence. The family often has to endure this heavy black cloud over them for several years before the suit even comes to trial.

A good prescription for coping with the threat of a professional liability suit is to spend time together as a family; preferably where the physician can be away from the telephone, beeper and office.

The support of friends is essential. Many county medical societies and auxiliaries have organized support groups that can be called upon at any time for help, love and, just as it is called, support. These groups are a comfort to the spouse who may be trying to "tune out" the torture that this family and marriage is undergoing. It will give the physician the opportunity to ventilate his or her obsessions regarding the vicious attack on their skills and abilities.

The physician is faced with many different problems directly keyed to the liability suit problems, therefore, it is wise to "Suit Proof" his/her assets. This could mean not funding IRAs; changing jointly owned property to tenants by the entirety; everything owned by the physician should be appraised; the possibility of factoring accounts receivable to banks so that they cannot be attached; critical decisions about pension funds. Yes, these steps to secure the future are not free.

Do you wonder what the medical profession will be like in 20 years?

Mrs. Milton R. (Jo) Tignor Jr.
North Palm Beach

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

APRIL

Otolaryngology in the Family Practice, April 1-2, USF College of Nursing, Tampa. Contact: James Endicott, M.D. (813) 972-8463.

New Approaches to Common Disorders, April 5-9, Holiday Inn Surfside, Clearwater Beach. Contact: Joel Gleason, M.D. (813) 397-5511.

1988 Florida Tutorial, April 6-8, Airport Marriott, Orlando. Contact: Sally O'Neill, Ph.D. (402) 280-4016.

Critical Care Medicine '88, April 6-9, Lake Buena Vista, Palace Hotel. Contact Patti Devlin, 305-841-5144.

Issues and Advances in Pediatrics, April 7-9, Sheraton Sand Key Hotel, Clearwater Beach. Contact: Herbert Pomerance, M.D. (813) 974-4214.

7th Annual Sportsmedicine Seminar, April 8-9, Holiday Inn, Pensacola. Contact: Garth Gove, M.D. (904) 474-7101.

Issues in Perinatal Care - 1988, April 8-9, Indigo Lakes Conf. Ctr., Daytona Beach. Contact: Mrs. N. Drane (904) 252-4701.

Challenges in Quality Assurance and Utilization Review, April 9, Tampa. Contact: Kathryn Corrigan, M.D. (813) 497-3340

Current Concepts in Pharmacology of Substances of Abuse and the Medical Management of Detoxification, April 14-16, Pensacola. Contact: Joy Harriman (904) 932-9375.

American Hospitals on Human Values: 1860-1988, April 14-16, Hyatt Hotel, Tampa. Contact: Lois Nixon, Ph.D. (813) 974-3294.

Focus on Education, April 18-20, USF College of Med., Tampa. Contact: John Malone, M.D. (813) 974-4360.

CREM IV - Toxicology/Neurology, April 18-22, Lincoln Harbour Hotel, Tampa. Contact: Registrar (214) 550-0911.

A Week of Medicine, April 18-22, Bonaventure Resort, Ft. Lauderdale. Contact: The Cleveland Clinic, 1-800-762-8173.

Substance Abuse: The Facts, April 21, Florida State University Conference Center, Tallahassee. Contact: Mollie Hill, 904-877-9018.

Techniques of Eyelid Reconstruction, April 22, Univ. of Miami, Miami. Contact: Larry Garland, M.D. (305) 547-4477.

Coronary Heart Disease: Current Concepts, April 22-23, Sheraton Royal Biscayne, Key Biscayne. Contact: Deborah Wilderson 1-800-421-3756.

Florida Heart Institute Cardiology Update, April 24-26, Sheraton World Hotel, Orlando. Contact: Rick D. Mace (305) 897-1575.

5th Annual Magnetic Resonance Imaging 1988, April 24-29, Palace Hotel, Lake Buena Vista. Contact: Dept. of Radiology (873-2090.

Continuing Controversies and Dilemmas in Anesthesia, April 29-May 1, Hilton Hotel, Pensacola Beach. Contact: Warren Sears (904) 435-1063.

MAY

Radiology Review Course '88, May 1-6, University of Miami, Miami. Contact: Carol Lamarre (305) 549-6894.

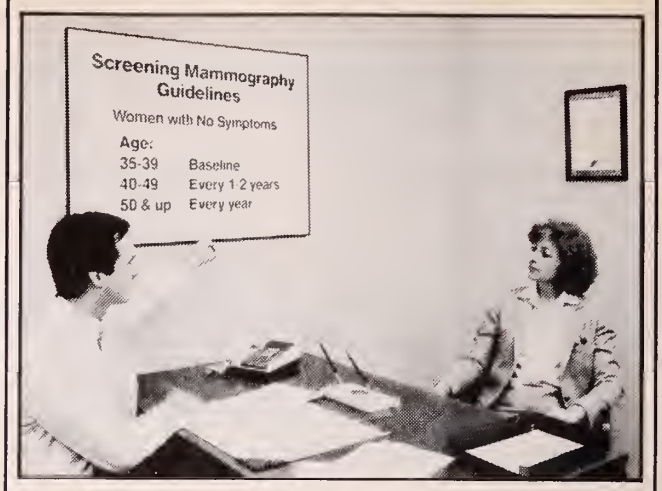
8th Review of Practical Dermatology for the Primary Care Physician, May 5-8, The Grosvenor, Lake Buena Vista. Contact: Elaine Halverson (904) 622-6315.

Current Concepts in Wound Healing and Photography for Cutaneous Surgery, May 10, Boca Comm. Hosp., Boca Raton. Contact: Larry Garland, M.D. (305) 547-4477.

Pediatric for the Practitioner: Update on Genetics, May 13, Sheraton Tampa East, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

ECG — STAT! May 18-22, Belleview Biltmore, Clearwater. Contact: Henry Marriott, M.D. (813) 894-0790.

Magnetic Resonance Imaging: A Technologists New World, May 19-21, Palace Hotel, Lake Buena Vista. Contact: Martin Silbiger, M.D. (813) 974-2538.



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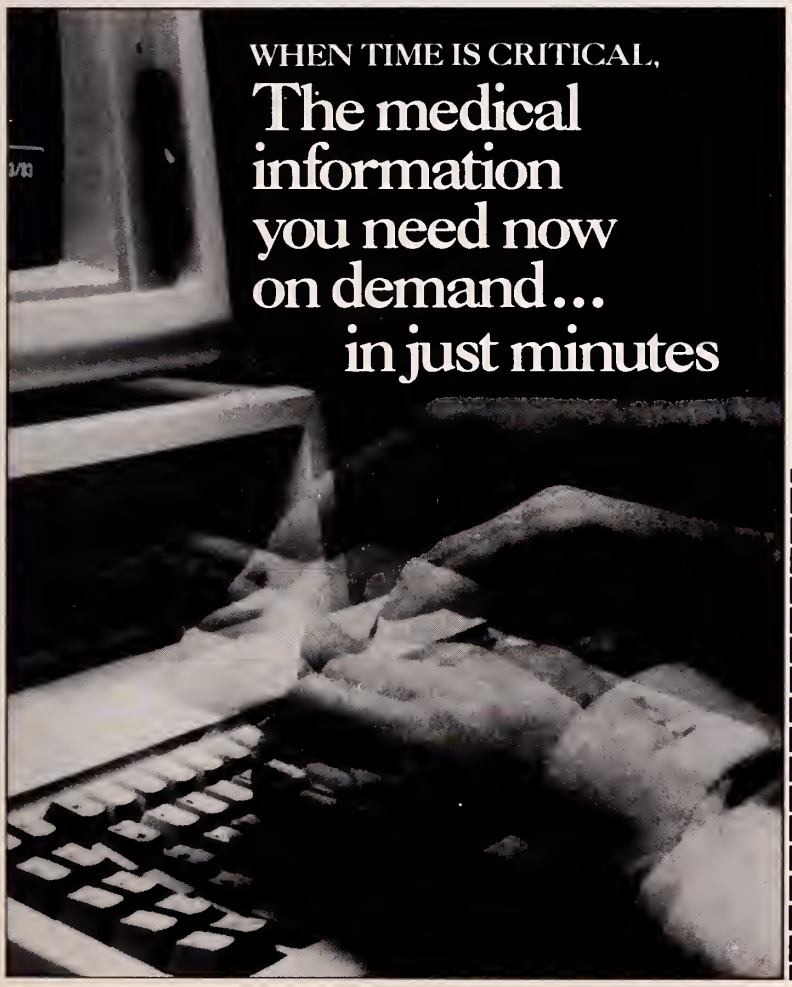

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Who should attend?	Beginning through Advanced Physician Broadcasters Health Reporters Spokespersons
When is it?	Thursday, April 21–Sunday, April 24, 1988
Where?	Hyatt Regency New Orleans
What is the program?	A combination of skills courses, plus issues discussions for health and medical reporters. Curriculum includes writing for broadcast, reporting, editing, voice and delivery coaching, podium speaking, plus an opportunity to discuss with peers the issues facing health and medical reporters throughout the country.
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Faculty:	Experienced physician broadcasters, network producers, writers and editors, broadcast executives and professional voice and speakers' trainers.
Fees:	No price increase in two years: $590 AMA Members $750 Non-member $200 Resident/Student/Retirees $200 Optional Professional Day Fee includes welcome reception, April 21, 6:30 p.m., continental breakfasts, luncheons, video and audio tapes, workshops and materials. Please make check payable to American Medical Association. We will confirm your registration by mail.

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Feature Editor — **Dale C. Havre, M.D.**

New Times, New Mores: The Rules Are Different Now

Surely there must be something amiss in our society when so many of us seem more interested in the second coming of the Jims (Bakker and Swaggart) than of Jesus. I get the same feeling when the studio audience cheers only the entrance of Larry, Darryl and Darryl on the Bob Newhart Show. And are we so lacking in real-life heroes that Peewee Herman gets the chance to become a national idol for our children?

I guess it's a matter of changing priorities and attitudes in our nation. While strolling around a university campus recently, I overheard a couple of students talking about their course selections for the next semester. One fellow wondered whether he ought to take the advanced marketing seminar or Accounting III. His companion was definitely in favor of the marketing course, because it offered more in the way of consumer demographics. That, he thought, would be more valuable in the real world. The badinage of bright business majors, right? Wrong. The fledgling entrepreneurs turned out to be medical students. I suppose it is inevitable that we shall begin to hear parents of young children say such things as, "Look, honey, I think we have a budding doctor on our hands. See how nicely he plays with the toy cash register!"

Apparently there is also a growing respectability for the second place in America. Some of us are having a terrible time accepting that attitude. I wonder if we can blame Avis? (Remember, to err is human but to think of someone to blame is genius — source unknown.) After all, wasn't it Avis that glamorized the runner-up position? It's hard to believe that we, as a nation, are so willingly allowing foreign investors to buy up our corporate giants. We are steadily losing our industrial supremacy without so much as a respectable squawk. Who knows what corrosive political forces will come into play as we become a renter nation? Is short-term profit really all that irresistible?

Nevertheless, CBS Records Group willingly spun its way into Sony's arms (for a mere $2 billion) and Japan's Bridgestone Tire has made tracks into the front office of the great Firestone Tire & Rubber Co. Can Big Blimp be far behind? Furthermore, since British Petroleum recently gobbled up what was left of Standard Oil Co. for a tidy $7.8 billion, I wonder if Medicare is in danger of a hostile takeover by Britain's National Health Service. It would serve them right — both of them.

Perhaps the new fellow in charge of the Health Care Financing Administration (HCFA), William Roper, M.D., will want to protect what is left of medicine's honor in the marketplace. He seems to be very bright and articulate, and he does sound as if he is properly respectful of his enormous responsibilities to both physicians and patients alike. Let us pray that Dr. Roper can survive the bureaucratic blunderbuss that will be perpetually aimed at his reasoning gland. With the number of medical school applicants dropping dramatically and creative biomedical research in danger of extinction, the medical profession is going to need all the help it can get.

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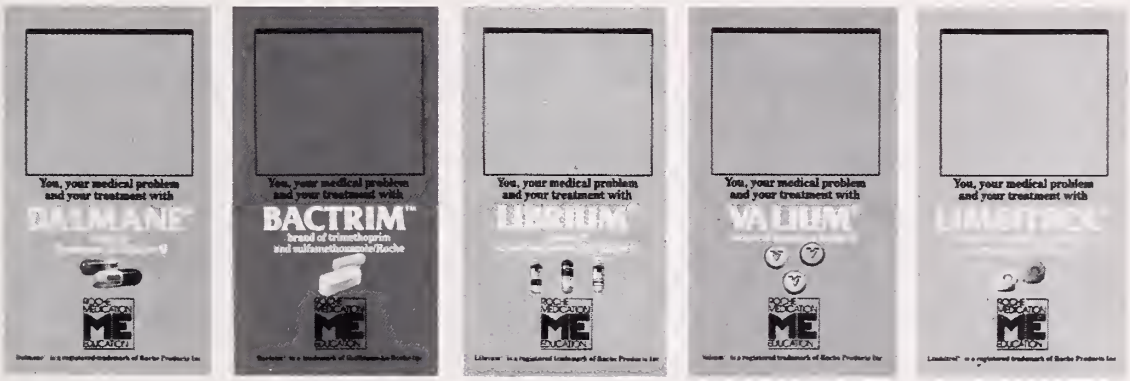

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COVER

Financial shelter from the legal storm highlights this month's issue of *The Journal*. With many physicians today becoming 'judgment debtors' with ominous regularity, asset protection is more important than ever. The work of artist Chris Armstrong, the cover graphically illustrates that when the rains come it is best to be prepared.

Editors Note: We are pleased to inform our readers that this issue of ***The Journal*** *was printed for the first time ever at Centurian Press, Inc., a wholly-owned subsidiary of the FMA.*

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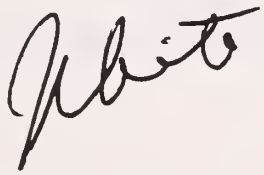
Super Tuesday — A Golden Opportunity That Slipped Away

Every physician, spouse and office person knows the current liability crisis is not over. They also know that our last hope for solving this problem depends on our garnering 340,000 petitions and then encouraging the citizens of Florida to vote for our amendment.

With the exception of several counties, i.e., Lee, Sarasota, Marion and Bay, Super Tuesday was a flop. This did not occur because our staff failed to provide each member with the necessary information and materials. It happened because most of the physicians in this state suffer from acute apathy. It is distressing to me that physicians are quick to complain about their high premiums, are often critical of the FMA leadership, and yet are unwilling to get involved and give two hours of their time to go to the polls on one day to ask the public for help. Not only would we have gotten 500,000 signatures, but the physicians would have felt a sense of accomplishment and may have rekindled a spark of hope in what to many must seem a hopeless situation.

We are currently 140,000 petitions short of our goal. This means that we need only 10 to 15 petitions per FMA member. You can get your quota in less than 15 minutes. I urge you to get involved and help YOUR organization reach its goal.

I am pleased with the strides we have made this year, but we still need each member of the Florida Medical Association to continue to be supportive and involved.



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EDITORIALS

The PRO Settlement: A Time to Heal Wounds

The simmering feud between Florida physicians and the state PRO came to an end last month with the out-of-court settlement of the suit filed by the FMA and 68 hospitals against the Tampa-based Professional Foundation for Health Care, Inc. (PFHC). Physicians and hospital spokesmen felt that they won major concessions and that the negotiated settlement will pave the way for more harmonious relations between the parties in place of the acrimonious battles of the past. We hope so.

Some of the basic issues settled would indeed appear to make the review process more fair and balanced than it had been in the past. These include directives to the PRO reviewers to hold telephone discussions with physicians before issuing denial notices, to identify their specialties during pre-denial discussions and reconsideration periods, and to give physicians and hospitals more specific information on why admissions are being denied. These provisions will replace what most physicians perceived to be a one-sided, arbitrary, and capricious review process.

Crucial to the successful implementation of a peer review process is the presence of qualified reviewers. This would obviate past complaints of cursory reviews done by whoever was available to do them. Many highly-qualified physicians are willing to serve as reviewers but find it hard to do so because they have to travel to Tampa, Tallahassee, or Fort Lauderdale. The state PRO needs to look into the possibility of doing more on-site reviews and employ the services at the same time of many community physicians. A single step like this would go a long way towards alleviating many of the problems that have beset the PRO in the past.

The new medical director of the state PRO, Dr. Charles Slonim, has been traveling across the state trying to make friends and explain the peer review process to physicians. Although I doubt that he has made new friends, he appears to be sincere and deeply motivated in making the process work not only for physicians, but ultimately for the interests of patients. In his appearances before medical staffs, he has met concerned, skeptical, and occasionally hostile physicians who are deeply disturbed about the workings of the PRO. He recognizes the problems, and it was in recognition of these problems that he is taking a substantial time out of his busy private practice to try to look for solutions. The negotiated settlement should give Dr. Slonim more elbow room to improve further the workings of the state PRO.

The former chairman of the FMA PRO Committee, Dr. Arthur Eberly, articulated well two other pressing concerns of physicians: the over-reliance of PRO reviewers on cookbook criteria over the clinical judgment of physicians, and the disposition of certain frail and sick elderly patients who may need more care than other Medicare patients. No one questions the need for guidelines but they need to be flexible enough to allow PRO reviewers a wider latitude in determining the validity of admissions based not on numbers and figures alone, but on the individual circumstances of each patient. Human illness, after all, varies from person to person and cannot be pigeonholed to fit computer criteria all the time. Dr. Slonim ought to look into these concerns seriously.

Physicians should give the state PRO a chance to work well under the new arrangements. The settlement should afford all parties concerned an opportunity to heal old wounds and to serve as a springboard for physicians and PRO reviewers to work harmoniously together. Let us not forget that the suit was filed for one reason: to protect the interests of patients. Whether the settlement works well or not, we need to continue to be vigilant in pursuing that goal.

R. G. Lacsamana, M.D.
Editor

Power Unused Is No Power

Over the past month physicians in Florida have been busily gathering petitions to place a $100,000 cap on noneconomic damages on the ballot in November 1988. That is to say that we have been extolled, exhorted and encouraged to gather petitions to place this amendment on the ballot for voters' approval. Even though the Supreme Court of Florida has found that the wording is constitutional and can go on the ballot, we still need approximately 380,000 signatures from registered Florida voters to place the amendment before the voters.

The Florida Medical Association has encouraged all physicians to gather petitions starting with Super Tuesday and trying to get the required number of petitions by the first of May. This would seem to be a logical and easy task. Physicians have complained that the malpractice crisis is driving up their premiums, hurting patient/physician relationships, is unfair in its application, and generally lines the pockets of a few trial attorneys at the expense of society as a whole. We have been saying this for years and have gone before the Florida Legislature on many occasions in order to get laws passed to change the tort system as it now exists in the state of Florida. The Florida Legislature recently passed a medical malpractice act in a special session, which was criticized by many physicians as not going far enough. Although there was much discussion and argument over the good of the recently enacted law, almost all physicians in the state of Florida felt that a $100,000 cap on noneconomic damages would really be the answer to the malpractice crisis.

There are over 28,000 physicians in Florida, with 22,000 of them being in active practices and 16,000 of them belonging to the Florida Medical Association. It would seem an easy task to get 380,000 signatures as that only averages out to about 20 signatures per practicing physician. Alas, that has not been the case. At the present time we have approximately 200,000 signatures and are laboriously moving forward trying to collect as many signatures as possible before the first week in May. It has proven to be a monumental task and one which has required much cajoling and prodding in order to get physicians to participate in the petition gathering process.

It has been astounding to observers that we have simply not gathered the required number of petitions in a short period of time. After all, if all physicians are for the amendment then it would seem to be a logical sequence that physicians would help participate in the petition drive. This has not been the case. Some of the areas in the state that have been the most critical of the Florida Medical Association and the recently enacted law have simply sat idly by while events swirled around and moved inexorably forward without their participation. I have simply been amazed at the power being unused. The fact of the matter is that if physicians cannot band together to wield their vast potential unused clout, then we will all go down to defeat together. It has been the same story over and over again. Physicians are usually the most critical of laws passed on the state level and are willing to discuss it endlessly over coffee in the doctor's lounge and to offer suggestion after suggestion on what they would do if they were in charge. The fact of the matter is that physicians are in charge if we would only wake up to our tremendous power and influence which we have in the state of Florida and indeed in the United States.

It has been a relatively easy matter to collect signatures and people are almost falling over themselves in order to sign the petitions. As a solo practitioner, this fact was hammered home to me on the first day that I gathered petitions and collected over 30. If every physician would have collected 30 signatures we would have close to 700,000 signatures and its place on the ballot would be assured at the present time. However, many physicians have chosen not to get involved even though they agree that the $100,000 cap is needed. They would prefer to leave it to someone else to do the work while they continue on not being interrupted with their patient visits and making sure that they are remunerated financially for those visits.

The excuses that I have heard are endless and range from the ridiculous to the ludicrous. I have been told by some physicians' office that this would "slow them down from seeing their patients". I realize that by getting signatures a physician may not be able to see as many patients as he usually does, but this is small comfort to the hundreds of physicians around the state who have taken days and weeks off from their work in order to make this amendment a reality and to place it on the ballot. It seems a small matter that a physician may see one or two patients less a day for a few days in order to collect signatures. However, if that extra money from seeing those one or two patients outweighs that physician's regard for his fellow doctors in the state of Florida, then I suppose he will continue as he has before.

Physicians have a tremendous amount of unused power and potential. However, no matter how potential that power is, as long as it is unused and untapped it will continue to be an impotent power. If the

physicians in the state of Florida do not get the required number of signatures, then we do not have the state legislature to blame it on, trial attorneys, the tort system, or a multitude of other factors which we have traditionally blamed our plight for. We will only have ourselves to blame and those who have sat idly by and have not raised a pen in order to collect one signature will be getting exactly what they deserve, which will be no mercy at the hands of the Florida Legislature and the trial attorneys in the state of Florida.

Unfortunately those thousands of other physicians who have made some effort to participate and to gather petitions will be in the same boat with those who have sat by and twiddled their thumbs while mouthing platitudes and suggestions for making things better.

That is little comfort for participating physicians, as all physicians wind their way inexorably "down the drain" if we do not get this amendment before the voters.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach

Primary Care Takes A Whipping

Bad news for the field of primary care is reflected in the results of the national matching program for interns and residents. Pediatrics and Family Practice took a beating, barely filling up 75% of available positions. Internal Medicine, traditionally attracting some of the brightest graduates, posted a 1% gain after losing 7% in 1987.

What is happening may be a temporary phenomenon, but I am not so optimistic. If the attrition in Internal Medicine is any portent, then we may be in for troubled times with an overabundance of physicians, and a problem of maldistribution as in the past. That will be bad for the public and the medical profession.

It is not difficult to speculate on why primary care is losing its attraction. Past polls indicated that medical graduates were not swayed by potential income in their choice of a specialty. That attitude may have been changed by the crunching economic realities of current medical practice. I am not implying that young physicians are losing their idealism; nevertheless, saddled with an average debt of $35,000 upon leaving medical school, most will be tempted to pass up the arduous hours and petty financial rewards of primary care for the greener fields of other specialties.

Financial consideration is not the only reason for increasing defections from primary care. Increasing third-party regulations, particularly from the government, devastatingly impact on general internists and family practitioners by stripping away their professional autonomy. The growth of organizations like HMOs also has tarnished the image of primary care practitioners, relegating them to the status of mere gatekeepers.

If erosion in the number of primary care resident physicians continues, we will have serious problems. Access to medical care will become limited; the poor and the uninsured will be shut out; emergency rooms will become even more crowded; and the costs of medical care will escalate further. Such a scenario will not endear us to our patients and the government. It may be the perfect set-up for the government to take over.

The solution lies in cooperative efforts by the government and medical profession. Bureaucrats need to ease their strangulating regulations while the HCFA should take quick steps to correct reimbursement inequities under Medicare. Perhaps the government-sponsored Harvard relative value study will bring more sanity to the reimbursement system. The report will be released in June. The medical profession may need to cut back on some specialty programs and reassign them to primary care. This would not be a popular move, affecting the free choices of physicians, but there appears to be no other solution to this problem.

If we lose in the field of primary care, we stand to lose much of what we have won for our profession.

R.G. Lacsamana, M.D.
Editor

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C I B A

LETTERS & VIEWPOINTS

Hooray!

After 36 years as a crusty old G.P., I never thought I would see the day!

After a million words of apology, excuses, self-pity, and perverted explanations of the profession's plight, finally there is a voice in the wilderness.

The article by Pepi Granat *(The Demise of the Independent Doctor: A Self-Fulfilling Prophecy,* February, 1988) was the most clear, concise presentation of our troubles and the cure that I have ever read.

Pepi, I love your insight and obvious respect and admiration for the profession.

You have my vote for president of the AMA.

Louis J. Marchetto, M.D.
North Palm Beach

Praise and Prejudice

I enjoyed very much the two special articles in February '88 JFMA by Drs. Havre and Granat *(Back-to-Basics: Survival Tips for Medicine* and *The Demise of the Independent Doctor: A Self-Fulfilling Prophecy).* I would like to see more articles like these oriented toward the basics of providing medical care.

I myself am a solo, independent radiologist. I was with a group practice for 10 years but because the group became a "factory" rather than a medical practice, I quit. Now, as a solo M.D., I can get the satisfaction of providing **my,** not a group's, brand of care. Group practice often becomes a tyranny of the most aggressive, loudest and money-hungry rather than mature and responsible members.

Hospital and medical politics and practice more and more are dominated by groups or alliances of groups or their leaders. The solo independent M.D. is often bullied or misled by these people on various issues. Why? Usually to gain or protect their financial base, not to provide medical service. And I believe the solo, independent M.D. has potentially the best chance of meeting the patient's and his own needs.

Sure, specialization has forced group practice to an extent but my own observation is that many groups are formed because the solo M.D. is scared off or intimidated by the so-called leaders of the medical community.

And the public in general has very little idea of the degree of greed and "factory" mentality that provides their care in many situtations. But they realize that doctors don't take the time to give them the **personal service** they want. They realize doctors make a lot of money and drive expensive cars, etc.

I fear our image is at a low point for sure. I believe you should encourage more articles of this "Back to Basics" philosophy and they would serve to improve the quality of medical care and also of our personal lives and those of our families.

Richard L. Stern, M.D.
Fort Pierce

A Realistic Look at AIDS

Dr. Brouillette's letter in the February FMA Journal certainly is a frightening script of what could occur with a "typhoid" epidemic in these times. I assume from his complaint about "our liberal and lawyer-infected society" that Dr. Brouillette is a conservative. As such, I am surprised that he did not refer to the Black Plague of the Middle Ages rather than a modern problem such as typhoid.

Fortunately, his scenario does not coincide with that of AIDS, the major medical problem of our times. The disease is transmitted by only three means, i.e., sexual, perinatal, and percutaneous. The Surgeon General and others have advised us that a vast educational program, accompanied by individual counseling, should be the chief thrust of our attempts to limit the spread of AIDS. This would be primarily directed toward the I.V. drug user, since this is becoming the major source of infection. The theory that these people are beyond reach can only be disproven by intensive efforts to treat the addictions of these pathetic and frightened human beings.

Since it is known that the HIV virus cannot be transmitted by casual contact, there is no concern with persons such as food handlers and an "AIDS Mary" would not exist. Quarantine is also not a viable option. This would doom perhaps millions of Americans to lifetime isolation at tremendous cost to our society. In the end, this would achieve nothing, since the HIV virus could only be transmitted by behavior with consensual others. Similarly, the danger from a nonviolent school child infected with HIV is nonexistent and there is no reason to not allow school attendance by afflicted children.

Although Dr. Brouillette may satirize the protection of the civil rights of Americans, he would probably agree that this very policy is what separates this glorious country from much of the rest of the world. It is also wonderful for me to be able to confer praise

on the AMA for its courageous decision that physicians are obliged to treat the sick, even if their life style is repugnant to them. It saddens me to know that the majority of physicians in our community (that of Dr. Brouillette and myself) would refuse to treat a person with AIDS.

Since my retirement last year, after 30 years of practice, I have become involved in teaching the medical and psychosocial aspects of AIDS at Rollins College in Winter Park, with my wife Judith Ziffer, Ph.D. Fortunately our postcourse surveys reveal that we have been successful in teaching the students that we are fighting a disease, not people with a disease.

Albert M. Ziffer, M.D.
Winter Park

House Call to Congress

I write to remind you and the members of the FMA that Jerry Schenken, M.D., a pathologist and a member of the Board of the American Medical Association and a Republican, is running for a seat from Nebraska in the United States House of Representatives and has a very good chance of winning.

Let me tell you why this is important to physicians in Florida. The federal government has shown that it is moving rapidly to expand its influence in our practice of medicine. Only one physician now sits in the Congress. We need all the help we can get. Jerry Schenken is a bright, energetic, articulate physician. He has demonstrated that in our behalf in his work on the AMA Board. He needs our support, our help, and some of our money. Please influence any friends in his district to vote for him. Send a check to his "Schenken for Congress" campaign fund.

Ronald A. Shellow, M.D.
Miami

Lessons From a Small County

The "Super Tuesday" effort in Marion County was by any standard a resounding success. We were able to mobilize the efforts of the Society and the Auxiliary on very short notice, and, with materials supplied by the Florida Medical Association, the effort looked organized and professional. That day, covering almost *80% of the polling places in this county, we collected 6,874 petitions.* All of us, even those of us who are incurable optimists, were amazed at how easy it was to get people to sign. Obviously, the public has been well educated about this problem. Of course, everyone pays an insurance bill directly or indirectly, and it appears as if the lessons are striking home at last. It is clear that the public wants a chance to vote on this issue, and with any kind of television campaign, this issue will pass. This is not to say it will be easy — it won't — but it will succeed. We also learned something else. We learned that the actions of the county medical societies of the more populated areas of the state do not match their rhetoric. Basically, either they are poorly organized or really do not care about this issue, or both. Can you believe that *four* congressional districts in Dade County (16, 17, 18 and 19) managed to collect just under 8,000 signatures on Super Tuesday? Two congressional districts in Duval County, the home base of the Florida Medical Association, managed just under 10,000 signatures. I suppose the FMA can use its financial resources to hire someone and collect the remaining signatures, but this money really needs to be spent on the media campaign this fall. We need to ask ourselves where the bulk of this problem really lies. We certainly cannot pull the weight of the whole state on our own, and if the larger counties do not genuinely perceive this to be a problem (obviously they are not putting their time and money where their mouths are), then I think we should spend less time on this issue and more time with our families. The larger populated areas of our state need to get their act together promptly and lead us on this issue. If they are unable or unwilling to do this, they will only have themselves to blame.

Karl M. Altenburger, M.D.
Ocala

Hired Guns

Much has been said about the malpractice crisis in Florida, tort reform, etc. In the coming months I am certain a great deal more will be said and I just wanted to bring the readers' attention to the expert witness who testifies for the plaintiff. Certainly there are well-meaning physicians who do testify in an honest fashion and in sporadic cases for the side of the plaintiff. However, we all have heard stories of the hired gun, where for the right amount of money, experts can be found who will testify on either side of an issue and say what is needed to bring a judgment for the plaintiff.

We recently had a rather nasty malpractice trial here in Panama City. After the trial I spoke to the defendant involved and was shocked to hear the stories that he had to tell about the criticisms that he received at the hands of an expert. I was also equally astounded to find out that this expert was one of the medical school professors from the University of Florida. I feel that there are more than two ways to treat most things and resent the medical school types

coming out into the trenches to try and tell us how everyone should be taken care of. I also resent the retrospective analysis done in these situations and the dogmatic treatment recommended by the expert.

I am certainly in favor of free speech and if the university wants to allow its professors to come out and ambush the practitioners, then that is its business. I no longer consider myself a dues-paying alumnus of the University of Florida.

Michael X. Rohan, M.D.
Panama City

Retired Physicians' Progress #2

The Senior Physician Associates AMI North Ridge Medical Center are now in their fifth year of functioning as a group. Two matters have emerged as most salient.

Professional Courtesy: senior physicians and their spouses fall ill. The attitude of AMI North Ridge Medical Center has been exemplary. The administration has stated that they accept Medicare assignment and supplementary insurance as full payment for services to Senior Physician Associate members and their spouses. With certain understandable exceptions, they have adhered to this policy.

As to the physicians on the staff, indeed of the community, the picture is not clearly delineated. Something like a tacit understanding exists that senior physicians and their spouses would be accepted as patients on assignment and supplementary. From time to time one hears that a member has some difficulty in this regard. But mostly one hears heartwarming reports of "professional courtesy" received in dignity as the present seniors used to render it.

While professional courtesy cannot be legislated, a position in this matter enunciated by the state, even the national medical society, seems to be in order.

Continuing Medical Education: CME credits are mandatory for keeping a valid license. For most of the senior physicians a valid license is a cherished symbol. They gladly accept the need for CME hours because, in addition, they afford them a means to fulfill their avid desire to hang on to medicine, to satisfy their craving to keep abreast.

To obtain the needed credits used to be easy: the Senior Physician Associates AMI North Ridge Medical Center provided eight monthly lectures a year. The rest came from attendance at the active staff meetings. As of lately some difficulties have arisen with regard to the latter.

See The Journal - February, 1984
See The Journal - July, 1986

It has become evident that the younger physicians feel crowded by the participation of 60 or 70 or even more seniors, a bit frustrated by their many comments and questions.

Again, tolerance cannot be legislated, but mutual understanding can be sought.

It is assumed that approximately 300 retired physicians reside in Broward County. Senior Physician Associates speak for more than half of these. Dade County in the east and many others on the west coast are said to have a goodly number of retirees.

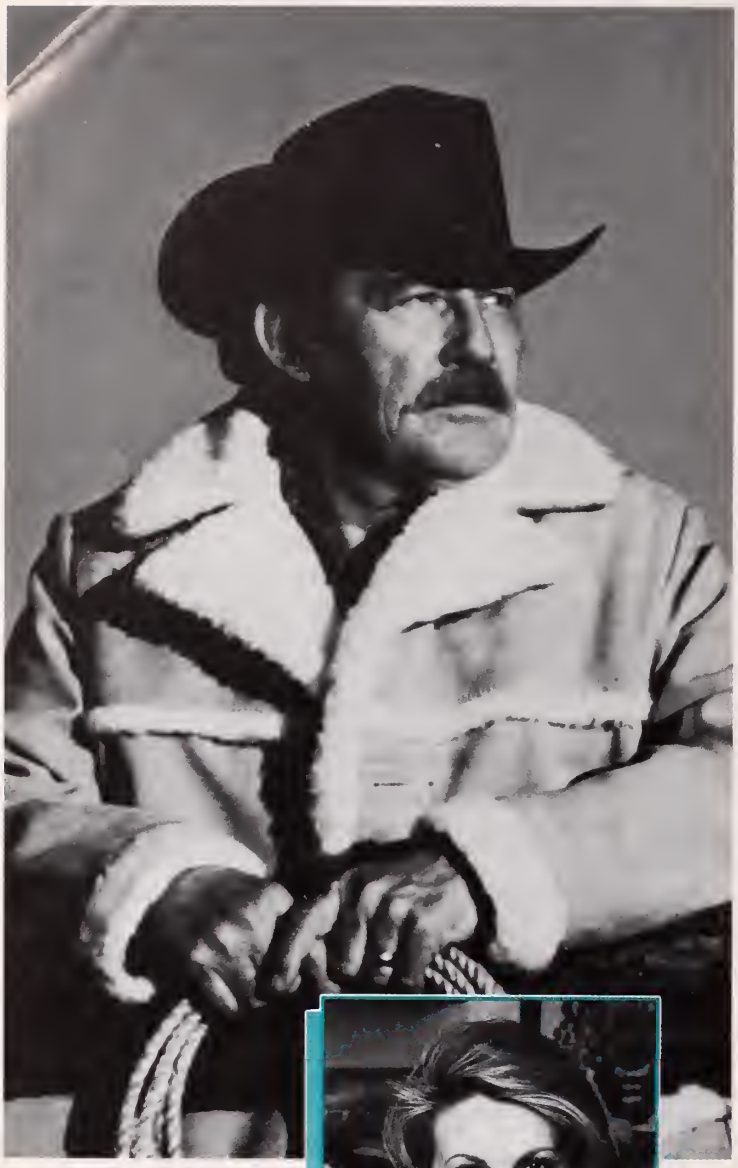
Most receive every year an acknowledgment from AMA and the state society where they practiced. But the journals, the means of communications, hardly contain features of concern to the retired doctor. They are addressed to the "providers." The retired doctor is now a "consumer" and a gap exists between the two. The gap is particularly distressing since the senior physician is still conditioned to feel like a provider.

Many retired physicians have until a few years ago been pillars of state and local medical societies. They deserve a means to voice their concerns. And there are some of these, in addition, to those mentioned.

The Florida state society with the many retirees within its borders should activate a committee composed of both practicing and inactive physicians to bridge the gap. The state medical society could grant the seniors space in their publication to air their concerns. Naturally, it should not be a one way street but a dialogue.

It may well be that the seniors of today can help the senior of tomorrow to reflect on matters of retirement in which they have acquired expertise.

Herman E. Mautner, M.D.
Fort Lauderdale



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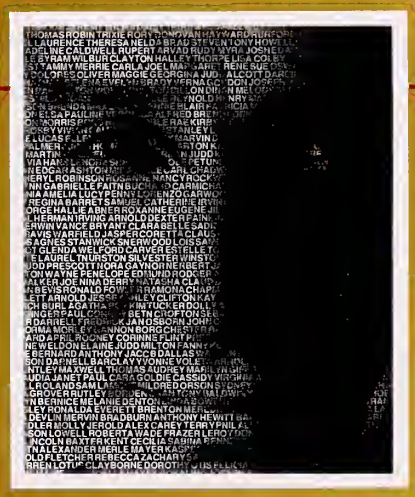

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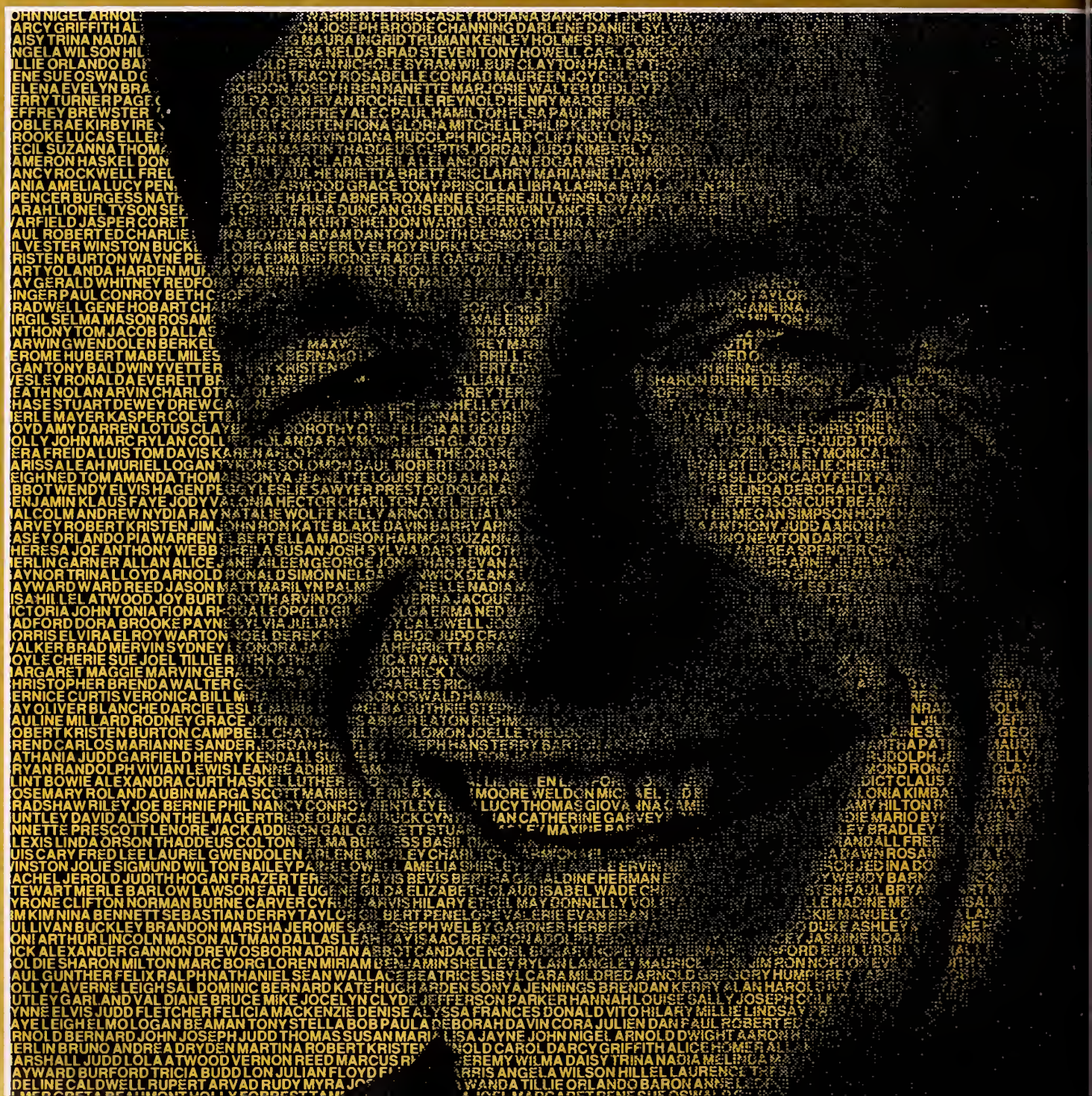

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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The original hydrocodone analgesic.

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INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Pulmonary Mucormycosis: *Case Report and Literature Review*

Joseph Boyd, M.D.

***ABSTRACT:* Pulmonary mucormycosis is a pneumonia caused by saprophytic fungi in the order Mucorales. It most commonly affects immunocompromised individuals and the fungi are very difficult to eradicate. Therapy for this illness is improving but mortality is still alarmingly high.**

The Author
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Case report • A 53-year-old black female with noninsulin dependent diabetes presented to the emergency department complaining of severe right-sided flank pain, anorexia, and a cough productive of yellow-brown sputum. The pain was dull and worse on inspiration. She denied chills or shortness of breath. She previously had been treated for pulmonary tuberculosis and had a 40-pack year cigarette smoking history. She also had a history of alcohol consumption.

Physical examination revealed a cachectic black female in moderate distress with temperature of 101°F and stable vital signs. The eyes, nose and throat were normal. Lung examination revealed right-sided basilar rales but no rub or wheeze. She had right flank tenderness to percussion. No clubbing of her digits was appreciated.

Laboratory studies revealed WBC 15,000 mm^3 with 24% bands and a hemoglobin of 12.4 gm/dl. The serum glucose was 676 mg/dl and acetone was reported as small amount present. She had a $p0_2$ of 95.8 mmHp and pH of 7.39 on a room air blood gas. Chest roentgenogram revealed a cavitary mass which was confirmed on CAT scan (Fig. 1).

She was hospitalized and placed on penicillin, IV fluids, and a sliding scale insulin regimen. The serum acetone cleared within the first 12 hours of therapy. Sputum specimens were sent for gram stain, routine culture, cytology and acid fast culture and stain. All initial stains and cultures were consistent with normal flora only. Bronchoscopy one week after admission showed diffuse erythema and no evidence of obstruction, tumor or foreign body. Cultures grew Group D streptococci. Gentamicin was added to the antibiotic coverage and over the next two weeks gradual overall improvement was noted. The pain resolved, but a low grade fever and cough persisted. The serum glucose remained between 200 and 350 mg/dl despite sliding scale coverage.

During the fourth week of therapy the pain recur-

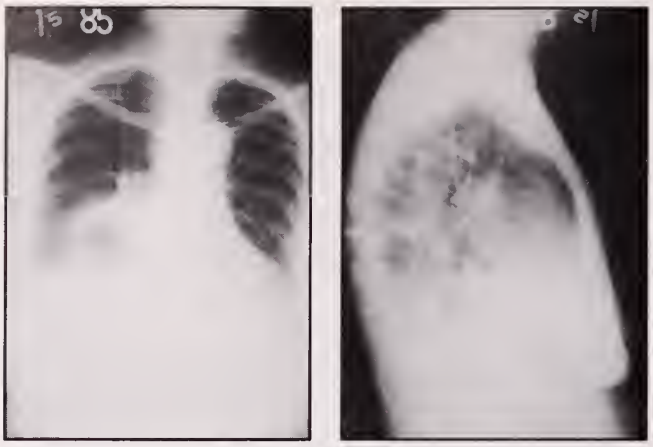

Fig. 1—Right lower lobe infiltrate showing cavitation.

red. A second bronchoscopy was performed because of persistent fever cough and pain. Biopsy revealed necrotic debris and fungi consistent with Mucorales. Amphotericin B was started, and after a 1 mg test dose, she was rapidly advanced to 45 mg per day. After receiving 375 mg, a right lower lobectomy was performed. During surgery the right thorax was irrigated with copious amounts of amphotericin B in saline. She tolerated the surgery well.

The specimen contained a 4.5 by 5 by 2 cm cavity filled with granular brown tissue (Fig. 2). The lung surrounding the cavity was congested and showed signs of chronic inflammation and fibrous pleuritis. Numerous fungal colonies consistent with Mucorales were found on microscopic examination, and Group D streptococci grew out on culture.

Postoperatively she received another 625 mg of amphotericin B and penicillin and gentamicin for the enterococcus. After four weeks of postoperative care, she was discharged with no requirement for insulin therapy. At her two year follow-up she is doing well.

Pulmonary mucormycosis ● Pulmonary mucormycosis is a fungal pneumonia most often associated with an immunocompromised host. The causative agents are fungi in the order Mucorales and genera Mucor, Rhizopus and Absidia. Mucorales are saprophytic but can be pathogens in individuals with diabetes, hematologic malignancy or on immunosuppressive therapy. The spores of these fungi are inhaled, thus the respiratory tract is the primary site of inoculation in man. The rhinocerebral form of mucormycosis is most common but cases of disseminated, cutaneous and GI mucormycosis have been reported.

The first reported case of pulmonary mucormycosis in the English literature was in 1948, and the first documented cure was in 1958. The mortality of pulmonary mucor is greater than 80% and most cases are diagnosed postmortem. There have been 21 reported survivors of this illness (Table I).

Over three fourths of the cases are in individuals with leukemia or a lymphoma, but over 80% of the survivors are diabetics. Little is known about the host defense against mucormycosis but leukocytes have recently been shown to be important. Obviously individuals with leukemia or on corticosteriod therapy have decreased functioning neutrophils, but the connection with diabetes is uncertain. Acidosis predisposes individuals to Mucorales infection but the occurrence of mucormycosis in well controlled diabetes mellitus has been documented. At present predisposition of diabetics to mucormycosis is uncertain.

Most patients present with fever, cough and chest pain. Of the 21 survivors 13 presented with fever and ten with a cough and increased sputum production. Two patients reportedly had complaints only relating to their diabetes and an infiltrate on chest roentgenogram. Hemoptysis is also common in this illness and massive hemoptysis is often the terminal event. Radiographic abnormalities include diffuse or nodular infiltrates, cavitary lesions or pleural effusions but the diagnosis cannot be made or excluded on these examinations alone.

The diagnosis of pulmonary mucormycosis is usually made on biopsy or bronchial washings. Cultures are frequently negative but positive cultures generally are consistent with an invasive infection. Eighty percent of the survivors were diagnosed on biopsy, (open lung, bronchoscopy or fine needle aspiration) and 15% were diagnosed on bronchial brushings. One case was diagnosed on culture. This illness is so

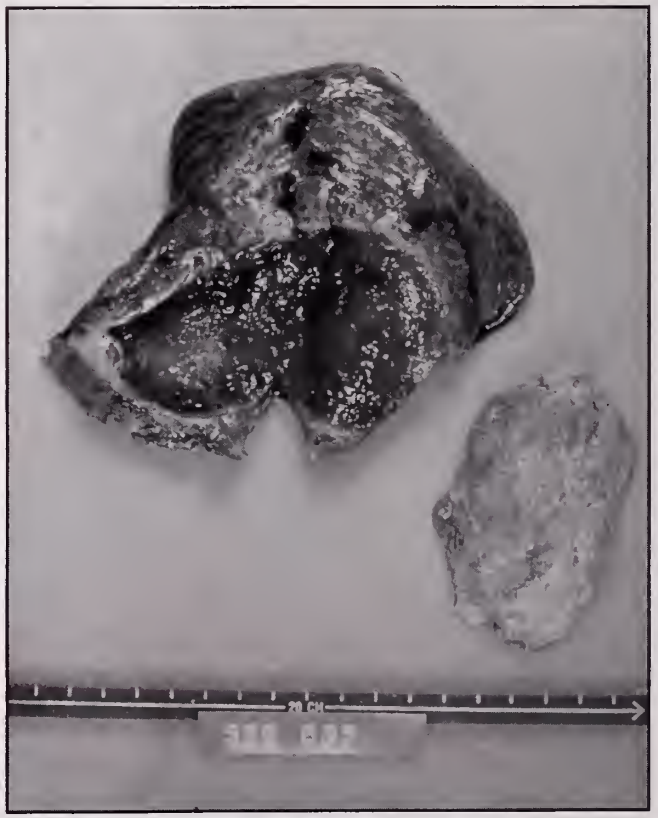

Fig. 2—Thoracotomy specimen showing cavity and necrotic debris.

Table I.—Reported Survivors of Pulmonary Mucormycosis.

	AUTHOR	YEAR	AGE	SEX	DISEASE	SYMPTOMS	DX	TX
1)	Dillon	1958	20	M	DM/DKA	F/Cough	Bx	Surg
2)	Blankenberg	1959	23	F	DM	F/Cough Hemoptysis	Surg	Surg
3)	Schwartz	1961	44	F	Histo	Hemoptysis	Surg	Surg
4)	Dillon	1962	15	M	DKA	—	Surg	Surg
5)	Medoff	1972	63	M	Leukemia	F/Cough	Bx	Ampho B 1.2 gm
6)	Gale	1972	48	M	DM	—	Surg	Surg
7)	Bogard	1972	12	M	Agammaglobulin	F/Cough	Cult	Ampho B .57 gm
8)	Hauch	1977	65	M	DM/CML	F/Weak	Bx Open Lung	Ampho B 2.1 gm
9)	Cohen	1977	52	F	DM	F/Cough	Bronch	Surg
10)	Brown	1977	38	F	DKA	F/Cough	Bronch Bx	Ampho B 3.11 gm
11)	Desouza	1978	47	M	DM	—	Bronch	Ampho B Surg
12)	Wright	1979	55	M	DM	—	Surg	Surg
13)	Eden	1979	3	M	ALL	F	Bx Bronch Needle	Surg
14)	Gribetz	1980	46	M	DM	F/Cough	Bronch Cult +	Surg
15)	Valcenti	1980	33	M	DM	Pain	Bronch Brush	Ampho B 2 gm
16)	Fahey	1981	58	M	DM	F/C/Cough	Bronch	—
17)	Schwartz	1981	20	F	DM	F	Bx Larynx	Ampho B Surg
18)	Griffin	1983	64	M	DM	F/Pain	Bx Needle	Ampho B 2 gm Surg
19)	Berns	1984	65	M	DKA	Cough	Bronch Brush	Ampho B .75 gm
20)	Santo	1986	37	M	DKA	F/C	Bronch Bx	Ampho B .14 gm Surg
21)	Boyd	1987	53	F	DM	Cough Pain	Bronch Bx	Ampho B 1.1 gm Surg

progressive that awaiting culture results usually is not prudent.

The specimens obtained from biopsy are stained with acid-Schiff or methenamine preparations. The fungi appear as nonseptate hyphae with right angle branching (Fig. 3). Mucorales typically invade blood vessel walls and cause thrombosis and hemorrhagic infarction.

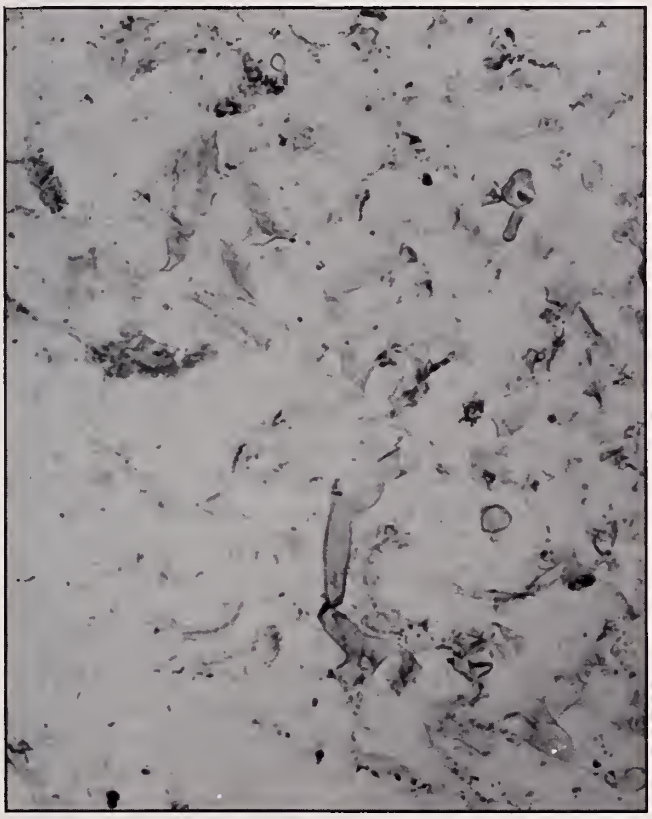

Fig. 3—Methenamine stain of biopsy showing hyphae consistent with Mucorales.

Successful medical management of pulmonary mucormycosis has been well documented. Six individuals have been cured without surgical intervention using amphotericin B. One patient was cured without any specific therapy. The total dose of amphotericin B ranged from 570 mg to 3110 mg with a mean of 2105 mg.

Surgery offers the best chance of recovery. Nine of the survivors were treated with surgery alone and six individuals were cured with a combination of amphotericin B and surgery. Over the last eight years the number of disease free survivors has doubled. This is due mainly to earlier detection of the fungi in biopsy specimens obtained during bronchoscopy, fine needle aspiration or open lung biopsy and brisk surgical intervention along with amphotericin B. As in our case, surgical therapy along with amphotericin B offers an improved chance of recovery.

Bibliography

1. Berns, J.S.; Lederman, M.M., and Greene, B.M.: Nonsurgical Cure of Pulmonary Mucormycosis, Am. J. Med. Sci. 287;42-44, 1984.
2. Bigby, T.D.; Serota, M.L.; Tierney, L.M., and Matthay, M.D.: Clinical Spectrum of Pulmonary Mucormycosis, Chest 89:435-439, 1986.
3. Blankenberg, H.W., and Verhoeff, D.: Mucormycosis of Lung: Case without Significant Predisposing Factor, Am. Rev. Tuberc. 79:357-361, 1959.
4. Bogard, B.N.: Pulmonary Mucormycosis, N. Engl. J. Med. 286:606, 1972.
5. Brown, J.F.; Gottlieb, L.S., and McCormick, R.A.: Pulmonary and Rhinocerebral Mucormycosis, Arch. Intern. Med. 137:936-938, 1977.
6. Cohen, M.D.; Brook, C.J.; Naylor, B., et al: Pulmonary Phycomycetoma in Patient with Diabetes Mellitus, Am. Rev. Respir. Dis. 116:519-523, 1977.
7. Desouza, R.,: Mackinnon, S.; Spagnolo, S.V., et al: Treatment of Localized Pulmonary Phycomycosis, South. Med. J. 72:609-612, 1979.
8. Dillon, M.L., and Sealy, W.C.: Surgical Aspects of Opportunistic Fungus Infections, Lab. Invest. 11:1231-1236, 1962.
9. Dillon, M.L.; Sealy, W.C., and Fetter, B.F.: Mucormycosis of Bronchus Successfully Treated by Lobectomy, J. Thoracic Cardiovasc. Surg. 35:464-468, 1958.

10. Eden, O.B., and Santos, J.: Effective Treatment of Rhinopulmonary Mucormycosis in a Boy with Leukemia, Arch. Dis. Child. 54:557-559, 1979.
11. Faney, J.P.; Utell, M.J., and Hyde, R.W., Spontaneous Lysis of Mycetomas After Acute Cavitating Lung Disease, Am. Rev. Respir. Dis. 123:336-339, 1981.
12. Gale, A.M., and Kleitsch, W.P.: Solitary Pulmonary Nodule Due to Phycomycosis, Chest 62:752-755, 1972.
13. Gribetz, R.A.; Chuang, M.T.; Burrows, L., and Teirstein, A.S.: Rhizopus Lung Abscess in Renal Transplant Patients Successfully Treated by Lobectomy, Chest 77:102-104, 1980.
14. Griffin, G.K.; Ellis, R.A., and Kim, T.C.: Cure of Isolated Pulmonary Mucormycosis: Case Report, Virg. Med. J. 110:550-552, 1983.
15. Hauch, T.W.; Pulmonary Mucormycosis: Another Cure, Chest 72:92-93. 1977.
16. Medoff, G., and Kobayashi, G.S.: Pulmonary Mucormycosis, N. Engl. J. Med. 286:86-87, 1972.
17. Santo, M.; Levy, A.; Levy, M.J., et al: Pneumonectomy in Pulmonary Mucormycosis Complicating Becnet's Disease, Postgrad. Med. J. 62:485-486, 1986.
18. Schwartz, J.; Baum, G.L., and Straub, M.: Cavitary Bistoplasmosis Complicated by Fungus Ball, Am. J. Med. 31:692-700, 1961.
19. Schwartz, J.L.; Nagle, M.G.; Akins, R., et al: Mucormycosis of Trachea, Chest 81:653-654, 1981.
20. Valcenti, J.F., and Conte, J.H.: Successful Medical Management of Pulmonary Phycomycosis, South. Med. J. 73:384-386, 1980.
21. Wright, R.N.; Saxena, A.; Robin, A.; and Thomas, P.A.: Pulmonary Mucormycosis Successfully Treated by Resection, Ann. Thorac. Surg. 29:166-169, 1980.

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Abstracts

Editor's Note: The following abstracts were presented by Florida resident physicians at the 1987 meeting of the American College of Physicians and Florida Society of Internal Medicine.

Fatigue and Chronic Anemia as the Presentation of Occult Panhypopituitarism

A 25-year-old white man was referred to the Hematology Service for evaluation of chronic anemia. Prior evaluation showed his hematocrit to be 34% with normal red cell indices, iron studies and vitamin B_{12}levels. Folate concentration was borderline low and the white blood cell count was 8000/mm^3 with 59% lymphocytes and 34% granulocytes. A trial of folate therapy had been ineffective.

Past medical history revealed an episode of acute meningitis at age 20 complicating chronic sinusitis. Periorbital edema and proptosis had prompted a head CT scan which confirmed the diagnosis of cavernous sinus thrombosis. Antibiotic treatment and intraoperative sinus drainage procedures failed to prevent the complication of permanent bilateral blindness. His course was further complicated by transient central diabetes insipidus. After resolution of meningitis and diabetes insipidus, he was discharged on no medications and was clinically stable over the next five years. He had no specific complaints but admitted to fatigue out of proportion to the anemia and typically slept 14 hours a day. This past history, along with the normocytic anemia with a relative lymphocytosis, prompted an evaluation for hypopituitarism. A random serum cortisol was decreased at 0.79 ug/dl (nl 5-25) and total serum T4 was also low at 3.09 ug/dl (nl 4.5-12.5). TSH was 0.66 uIU/ml (nl 0-7.6). He was admitted to the Medical Service to further evaluate panhypopituitarism.

Physical examination revealed a pale young man with pulse of 82/minute, blood pressure 120/80/mmHg without orthostasis, and respirations of 18/minute. He was afebrile. His pupils were dilated and nonreactive; he was totally blind bilaterally. He had no chest or axillary hair, normal thyroid gland, but small testes and prostate. His deep tendon reflexes were slow on return. Admission laboratory procedures revealed hematocrit 34%, white blood count 8,800/mm3 with 45% lymphocytes, and normal concentrations of electrolytes, BUN, and creatinine. Liver function tests were normal. Urinalysis and chest x-ray were unremarkable. Endocrinologic evaluation included 8AM cortisol of 0.3 ug/dl (nl 5-25), which increased to 2.71 after Cortrosyn stimulation. ACTH was borderline at 21 pg/ml (nl 20-140), FSH low normal at 8 mIU/ml (nl 2-46), prolactin 1 ng/ml (0-20), and testosterone low at 239 ng/dl (300-1,000). TRH stimulation confirmed pituitary insufficiency; TSH increased from a baseline of 0.73 uIU/ml to only 1.72, 60 minutes after TRH infusion. Head CT showed no masses and normal cavernous sinuses. The patient was begun on prednisone 5 mg q AM and 2.5 mg q PM along with Synthroid 0.1 mg q day and was discharged. Follow-up at six weeks revealed a very pleased patient whose sleeping pattern had changed from 14 to eight hours a day. The hematocrit had increased to 43%, and his white count was 16,900/mm3 with 13% lymphocytes.

In summary, this young man presented five years after cavernous sinus thrombosis with nonspecific complaints, coupled with chronic anemia and relative lymphocytosis. These laboratory abnormalities provided an important clue to pursue which eventually confirmed the diagnosis of panhypopituitarism.

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HTLV-I Lymphoma

A 60-year-old Hispanic man was brought to the Jackson Memorial Hospital emergency room with altered mental status. On arrival he was stuporous and unable to provide any history. Physical examination revealed only a 1x2 cm right axillary lymph node. Laboratory findings were significant for BUN 149, creatinine 4.9 and calcium 19.2. The patient was aggressively hydrated, with improvement in renal function and reduction in calcium. His mental status improved.

Further history revealed that he was a native of the Dominican Republic and had moved to the United States ten years ago.

A lymph node biopsy was performed which revealed large cell immunoblastic malignant lymphoma. The patient was found to have positive serology for the human T-cell leukemia/lymphoma virus (HTLV-I).

HTLV-I was the first of the retrovirus group to be identified. This is a family of RNA viruses which include the HTLV-III or human immunodeficiency virus (HIV), the AIDS virus. The HTLV-I probably originated in West Africa and spread to Southern Japan as well as the West Indies via the slave trade.

The virus causes a very aggressive leukemia/lymphoma which usually presents with either cutaneous lymphoma or hypercalcemia. Bone marrow involvement as well as a severe peripheral leukocytosis are frequently present although both were absent in this patient.

The disease frequently initially responds well to chemotherapy but relapses quickly to a very resistant form. Average survival after diagnosis has been reported as low as four months to one year.

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Hypodipsia and Partial Destruction of the Osmoreceptors

A 36-year old Hispanic man without significant past medical history presented to the emergency room complaining of a one-month history of general malaise, myalgia and mild increased urinary frequency. The patient denied taking any medications and hypodipsia or head trauma. Review of symptoms was otherwise negative in detail. Physical examination was remarkable only for mild orthosatic hypotension, dry mucosa and mild calf tenderness. Neurological examination was entirely unremarkable. Laboratory data on admission were pertinent for an initial serum sodium of 189, BUN 40, Cr 1.7, CPK 1024 (100 mm/%), serum osmolality 383, urine osmolality 1,228, Una 101. Urinalysis was remarkable for a S.G. of 1.035 without evidence of blood or protein.

Further study revealed normal hypothalamic and pituitary function with a normal ADH, prolactin, TSH, LH, FSH, testosterone and cortical values. Structural abnormalities were ruled out with a normal CT and MRI of the brain including pituitary fossa views. The patient was initially hydrated with normal saline in an attempt to decrease the serum Na approximately 1 mEq/hr. Based on the subsequent decrease in serum Na relative to the decrease inurine osmolality, we felt that his primary problem was hypodipsia and partial destruction of the osmoreceptors.

Although this entity has been previously described, it is most often seen in association with vascular, neoplastic, or granulomatous disease. The exact etiology of this patient's syndrome remains idiopatic. The patient has been subsequently placed on a high fluid diet and chlorpropamide to help promote ADH release and is currently doing well maintaining a serum Na of approximately 150.

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Partial Central Diabetes Insipidus as the Presentation of Systemic Sarcoidosis

This 65-year-old white man ws referred to Shands Hospital for evaluation of central diabetes insipidus. He had been in a normal state of health until six months prior to admission when a frontal headache developed associated with anorexia, polydipsia and urinary frequency and urgency. He had nocturia approximately five to eight times per night. Because of these symptoms, he consulted a urologist who performed a prostate biopsy which showed no malignancy but some peculiar-appearing cells. He was thought possibly to have diabetes insipidus and was referred to our hospital.

On presentation, he was well-appearing with normal vital signs. The physical examination was unremarkable with specific reference to normal funduscopic evaluation. There were no lesions seen in the ENT area. There was no adenopathy. The chest, heart and abdominal examination were normal. The skin was normal. His hematocrit was 41% and evaluations of white count, platelet count, electrolytes, calcium, and liver function tests were normal. The ESR was 7mm/hr, BUN 16mg/dl, and serum creatinine 1.0mg/dl. Urinalysis showed clear yellow fluid with a pH of 6.0, specific gravity of 1.016, and normal analysis by dipstick and microscopy. His urinary output was 7-8 liters per day with serum sodium concentrations of 142-149 mEq/L. A water deprivation test was consistent with diabetes insipidus during which time his body weight fell from 100 kg to 93 kg over the ensuing 12 hours. At the end of the test, urine osmolality was 195 m0sm and serum osmolality 295 m0sm.

When DDAVP was administered, his urinary

osmolality quickly rose to 340 mOsm. A PPD was negative with positive controls. Electrocardiogram was normal. Chest x-ray showed a 4 cm right upper lobe mass. Pulmonary function tests were normal. On computed tomographic examination, the head and sella were normal while the chest showed the mass seen on chest x-ray as well as multiple small right hilar and mediastinal nodes. Bronchoscopy showed no endobronchial lesions; washings were negative for tumor and AFB. Transbronchial biopsy of the lung mass was inconclusive showing only "no evidence of malignancy".

He then underwent thorocotomy and right upper lobectomy which revealed multiple large mediastinal and subcarinal nodes as well as the right upper lobe mass. Microscopic examination showed multiple non-caseating granulomas.

A review of the previous prostate biopsy showed cells and tissue consistent with sarcoidosis. Approximately 1% of all patients with diabetes insipidus are found to have sarcoidosis as the etiology. This case is presented as one in which diabetes insipidus served as the initial presentation.

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A 21-Year-Old Man with Fever, Weight Loss, Arthralgia, and Fatigue

A healthy 21-year-old black man presented with a nine month course of progressive fatigue accompanied by a weight loss of 25 pounds, fever and arthralgia of the left knee and wrist. The patient had been seen twice during this period and was once told he was "anemic". Previously his health had been good without any hospitalizations. He was a nondrug user, heterosexual, and had no contact with anyone with hepatitis.

Physical examination was positive for pale conjunctiva, a hard palate with multiple whitish shallow ulcerations, bilateral shoddy posterior cervical lymphadanopathy. The heart, lung and abdominal examination was negative. Multiple small purplish nonraised tender lesions were detected on the fingertips of both hands.

The laboratory examination was pertinent for a depressed white count at 3,600 with a hemoglobin of 9.8 gm and a normal platelet count. Electrolytes and chemistries were normal as was his chest x-ray and electrocardiogram. An urinalysis revealed proteinuria as well as pyuria and hematuria without bacteria.

A wide differential diagnosis was entertained which included entities such as lymphoma, collagen vascular discease, extrathoracic tuberculosis, vasculitis, systemic lupus erythematosus, primary renal disease, and AIDS. Extensive laboratory studies confirmed the diagnosis of SLE. An ANA was 1:1024 in a speckled pattern. Complement levels were depressed and a 24-hour urine protein revealed 4.7 gm with a normal creatinine clearance. A renal biopsy revealed focal and segmental proliferation of glomeruli and was interpreted as showing focal glomerulonephritis, high activity.

Different parameters of SLE are reviewed as well as criteria for diagnosis. While this disease is more common in young women than young men, certainly it must be considered in the differential diagnosis of any individual with a chronic systemic illness.

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Beta Hemolytic Streptococcus Causing Pericarditis

Beta hemolytic streptococcus is most commonly a pathogen in neonatal sepsis. In adults it rarely causes endocarditis but, when it does, it may be associated with myocardial abscesses and purulent pericarditis.

This report describes a patient who presented with pericarditis with associated cardiac tamponade caused by beta hemolytic streptococcus without associated endocarditis or myocardial abscess.

A 72-year-old man was admitted to the hospital with progressive shortness of breath, dypsnea an exertion and pedal edema for two weeks prior to admission. He had a previous leg injury that had become infected. On physical examination the blood pressure was 100/60 with a pulsus paradoxus of 20 mmHg. His pulse was 130 and respiratory rate 32 which was labored. There was jugular venous distention to the angle of the jaw. Bibasilar rales were heard in the chest and an anterior pleural friction rub was present along the left sternal border. He had a rhythm consistent with atrial fibrillation and a three-component friction rub over his heart. His liver was enlarged and there was 2+ pretibial edema to the knees. Laboratory studies revealed hemoglobin 10.8 gm, white count 42,300 with 78% polys, 12% bands and 2% metamyelocytes. The BUN was elevated to 62 mEq/L and sodium was depressed to 122 mEq/L.

The x-rays showed an enlarged heart with air fluid levels at the left heart border. A Swan-Ganz catheter revealed equalization of pressures and an echocardiogram demonstrated a large anterior and posterior pericardial effusion with diastolic collapse of the right ventricle. Pericardiocentesis was performed which revealed 250 cc of purulent material that grew Group B beta hemolytic streptococcus. Blood cultures were positive for the same organism and the patient responded to administration of penicillin G.

The causes and physiology of pericarditis are reviewed and the case is discussed in relationship to this unusual pathogen as an etiological agent.

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Thyrotoxic Periodic Paralysis: A Rare Entity in Caucasians

Although rare in the western world, thyrotoxic periodic paralysis (TPP) is seen frequently in the Oriental population. Familial and thyrotoxic periodic paralysis are identical syndromes characterized by acute episodic flaccid weakness, diminished deep tendon reflexes, and extreme hypokalemia. Management consists of correcting the transient hypokalemia and ultimately the thyrotoxic state. Once the patient is euthyroid, the attacks do not recur and reportedly cannot be induced.

I report two young healthy Caucasian men with this syndrome within a six month period. The first, a 31-year-old man, awoke at 3 a.m. unable to arise from bed. Upon presentation, his weakness was resolving, K^+ was 1.7, and T_4 17. After treatment for Graves' disease, he remained asymptomatic. The second, a 35-year-old tennis coach went to the theatre and was unable to arise from his seat. His K^+ was 2.1 and T_4 23.5. An unusual finding was hyperreflexia during his paralytic attack; this phenomenon was reported only once before in the literature.

Although reports of TPP in Caucasians are rare, we observed two such cases within six months. This suggests that TPP may be underdiagnosed and should be included in the differential diagnosis of acute nonfocal weakness.

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Impact of Percutaneous Renal Biopsy on Clinical Management at a Private Community Hospital

The purpose of this study was to examine the complication rate and clinical impact of percutaneous renal biopsy at a private community hospital in which the primary care physicians are often resistant to the recommendation by a nephrologist that his/her patient undergo biopsy. The relative risks and benefits of renal biopsy in such a setting were evaluated.

The medical records of 60 consecutive patients who underwent renal biopsy at Orlando Regional Medical Center (ORMC) during 1986 were reviewed. Sixty-two biopsies were performed by four attending nephrologists. There was one major complication (1.6%). A specific diagnosis was obtained in 55 cases (88.7%) while four biopsies (6.5%) were nondiagnostic and three (4.8%) were normal. Major therapeutic changes were made on the basis of the biopsy in 28 (45.0%) cases. Fifty-seven biopsies (91.9%) yielded significant information concerning prognosis of the renal lesion.

These results compare very favorably with results of similar studies conducted at university centers. In particular, therapeutic changes based on biopsy results are higher than previously reported. This may be due to the more discriminating selection of patients for biopsy at a private hospital. Percutaneous renal biopsy in a private community hospital setting is a low risk procedure which has significant impact on patient management.

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Adult-Onset Still's Disease Presenting as Fever of Unknown Origin

Adult-onset Still's disease (AOSD) is an uncommon relapsing systemic inflammatory disorder of unknown etiology and pathogenesis. Because of the relatively successful response to treatment, it should be considered in the differential diagnosis of fever of unknown origin. Also early diagnosis may save the patient from unnecessary or costly procedures.

Recently a patient was seen whose clinical course illustrates these important points.

A 35-year-old white man presented with a three-day history of high fever, chills, sore throat, non-purulent cough, pleuritic chest pain, bilateral shoulder pain, nausea, vomiting and epigastric pain. He has undergone splenectomy for trauma. Physical examination showed a temperature of 39°C, pulse of 150, dry mucosa, fine left basilar rales, mild abdominal tenderness and left shoulder tenderness. Laboratory studies showed a leukocyte count of 31,800/mm_3 with 78% segs and 15% bands. Urine analysis was positive for trace blood and 2+ protein. Erythrocyte sedimentation rate (ESR) was 75 mm/hr.

The patient was initially placed on broad spectrum antibiotics for a presumed pneumonia or intra-abdominal infection. However, he remained febrile, spiking quotidian evening fevers to 40°C, and an evanescent erythematous macular rash was noted. The leukocyte count rose to over 50,000/mm_3 and the ESR peaked at 120 mm/hr. Pleural and pericardial effusions developed requiring pericardiostomy and thoracostomy procedures. During 48 days in the hospital (34 days in the ICU) he was seen by ten consult services and underwent numerous invasive tests including bone marrow biopsy, bronchoscopy, lumbar puncture, sigmoidoscopy and skin biopsy. He also required several blood transfusions for a persistent normocytic anemia. Blood cultures were remarkable for a nosocomial K. pneumoniae bacteremia. Negative serology for rheumatological disease included rheumatoid factor, ANA, anti-DS-DNA, anti-SM, anti-ribonuclear protein and Sjogren's antibodies A and B.

On the 38th day of hospitalization the patient was seen by a rheumatologist who suggested the diagnosis of AOSD. Indocin SR 75 mg po bid was started. The patient defervesced within 48 hours with a remarkable improvement in symptoms. Forty-eight days after admission he was discharged afebrile with a declining leukocyte count of 32,500/mm_3.

The diagnosis of AOSD is based on clinical findings without benefit of serologic or other diagnostic tests.[1-4] Compounding the diagnostic problem is that, unlike SLE for example, there are no universally agreed-on criteria for diagnosis. The seminal features are, however, high quotidian fever, evanescent macular rash, arthralgias or arthritis and leukocytosis. The clinical course is highly variable and unpredictable ranging from a relatively benign, short-lasting illness to a severe, disabling articular disease. It is now realized that considerable morbidity and mortality is associated with the diagnosis and treatment of AOSD. In a recent study involving 21 patients, over 100 hospitalizations and 133 invasive procedures were performed including six exploratory laporatomies.[5] Treatment involves a step-wise approach with salicylates and NSAIDS as first line agents. However, in up to 50% of cases, steroid therapy, usually high dose prednisone, is necessary.

In summary, AOSD is a fairly well characterized disease entity. It should be considered when faced with the uncommon patient presenting with high spiking fever accompanied by an evanescent macular rash, arthralgias or arthritis and leukocytosis. Early diagnosis will avert delay in initiating therapy and may save the patient from unnecessary or unwarranted procedures. The physician should be aware of the potential for reoccurrence, life threatening organ involvement and therapeutic complications.

References

1. Bywaters, E.G.L.: Still's Disease in the Adult, Ann. Rheum. Dis. 30:121-133, 1971.
2. Esdaile, J.M.; Tennenbaum, H., and Hawkins, D.: Adult Still's Disease, Am. J. Med. 68:825-830, 1980.
3. Elkon, K.B., Hughs, G.R.V., et al: Adult-Onset Still's Disease, Arthritis Rheum. 25:647-654, 1982.
4. Larson, E.B.: Adult Still's Disease, Medicine 63:82-91, 1984.
5. Cush, J.V.; Medsger, T.A., et al: Adult-Onset Still's Disease, Arthritis Rheum. 30:186-193, 1987.

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C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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INDICATIONS AND USAGE
BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.
1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function, potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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SPECIAL ARTICLE

The Physician as Judgment Debtor

Mark E. Raymond

"One may sojourn on the beaches of the gold coast of Florida with property values reaching to the stars and keep a homestead of unlimited value free of claims of the trustee of creditors."
Bankruptcy Judge George L. Proctor, 1982

Particularly during today's often hostile environment, physicians must plan very carefully to protect their future financial security. One element of any such plan must include the anticipation of and protection against adverse judgments. Although one may obtain a degree of judgment "proofness" by liquidating his or her practice, selling everything and retiring to a sunny beach in the Bahamas, the timing may not be just right.

This article reviews the law regarding the availability of assets of the physician (although the principles presented herein apply to all persons) to the claims of judgment creditors, and discusses how physicians can protect their assets. The ability of creditors to seek satisfaction from the physician's assets is discussed, not the methods whereby the physician may attempt to limit his or her liability for malpractice or other claims of creditors.

The Author
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Mr. Raymond is a lawyer with the West Palm Beach firm of Moyle, Flanigan, Katz, FitzGerald and Sheehan, P.A. This presentation is based on his article published in ***On Call,*** *the bulletin of the Palm Beach County Medical Society, which is reprinted here with the Society's permission.*

Creditors' rights generally ● Unless the physician voluntarily pays an adverse judgment his or her creditor must resort to post-judgment proceedings in order to seek payment. Through the use of the various post-judgment procedures, all nonexempt property and property rights of the physician will be available to satisfy claims of his or her judgment creditor. Thus, the ability of a creditor to obtain property depends basically upon the existence of two facts: (1) the property is owned (to some extent) by the physician and (2) the property is not exempt from creditors' claims.

Property of the debtor ● Property subject to creditors' claims includes property in which the physician has a legal interest, for example, as sole owner or joint tenant, or an equitable interest, for example, as beneficiary of a trust.

If the physician is the sole owner of nonexempt property, it may be reached through legal process and is subject to the claims of creditors. Examples would be an interest in a partnership whether general or limited; real estate; stock and securities including stock in a professional corporation; savings accounts, checking accounts, certificates of deposit and other forms of cash account. From a liability point of view, sole ownership of assets is the most risky.

Generally a creditor may at best "step into the physician's shoes" with respect to property rights. For example, nonexempt solely owned property subject to a valid mortgage would be subject to a creditor's claim but such creditor would obtain the property subject to the mortgage, i.e., would only obtain the physician's equity interest. When a physician owns a divided interest in property such as a share as a tenant in common or as a joint tenant with rights of survivorship, only the physician's interest may be reached to satisfy a creditor's claim; the creditor generally could then force a partition or sale of the property to the same extent that the debtor could have. Thus, joint

tenancies and tenancies in common are just as risky as sole ownership.

Tenancy by the entireties ● When property is held by a husband and wife as "tenants by the entireties," under Florida law the property cannot be reached by a creditor to satisfy a debt of one spouse. However, if the husband and wife are jointly obligated for the debt, the creditor may subject the property to the satisfaction of the debt. Since it is unlikely for a husband and wife to be jointly obligated under a judgment arising out of the professional practice of one spouse, the tenancy by the entireties is an easy and effective vehicle for protecting assets from malpractice or other debts.

Entireties property is immune from claims of creditors pursuant to a metaphysical concept that developed at common law from the biblical declaration that a man and his wife are one. The theory is that the marriage is an entity, separate from the husband and wife, that owns the property, so neither husband nor wife have any right to the property. Thus, entireties property is not *exempt* from claims against one spouse; rather it is immune from such claims because it is not "property of the (individual) debtor." The immunity of entireties property from debtors of one spouse is firmly entrenched in Florida law. Even the Internal Revenue Service is prohibited from levying upon entireties property for the tax liability of one spouse (of course, the tax liability arising out of a joint return will generally be that of both spouses).

In Florida, both real and personal property may be owned by spouses as tenants by the entireties. In fact, when real property is acquired in the name of a husband and wife, for example, "John and Sara Doe," there is a legal presumption that a tenancy by the entireties has been created.

With respect to most personal property owned by a husband and wife there is no presumption that a tenancy by the entireties exists, but rather proof is required of the intent of the owners to create an estate by the entireties. Thus, for example, with respect to bank accounts, cars, boats, mortgage receivables, notes, and any other property where ownership is evidenced by a formal document, the ownership of the husband and wife should be stated in terms such as "John and Sara Doe, as tenants by the entireties."

With respect to interests in property where ownership is not customarily documented it is more difficult for a debtor to prove the existence of tenancy by the entireties. There is a difference of opinion among Florida courts regarding the ownership by a husband and wife of household goods, furniture, and furnishings. In one case a Florida court found that household goods and furnishings purchased solely with funds of the husband were presumed to be entireties property. However, in a later case another court held that absent proof of intent, household furnishings of a husband and wife were not entireties property even though bought with joint funds for the joint use of the spouses.

In view of this difference of opinion, it is probably wise to establish by appropriate documentation the intent of a husband and wife to own various items of personal property as tenants by the entireties rather than as tenants in common or as sole owners. A husband and wife owning property with no evidence of the form of ownership should execute affidavits designed to evidence their intent to own property listed in the affidavit as tenants by the entireties. With respect to future-acquired property it would be advisable to obtain a bill of sale for the item showing the purchaser as husband and wife, as tenants by the entireties.

There are three significant advantages to using a tenancy by the entireties rather than transferring ownership (by gift or otherwise) to a spouse or other person with low liability exposure: (1) the tenancy is protected from claims against either the physician or spouse; (2) in the tenancy the physician may be better protected against the perils of marital discord; and (3) upon the death of one spouse property held by the tenancy passes automatically to the survivor outright without the need for probate.

There are two potential disadvantages to owning property as tenants by the entireties. First, when spouses divorce, a tenancy by the entireties terminates by operation of law and each spouse becomes a tenant in common. The interest of a divorced spouse in the property may then be levied upon by the spouse's creditors (but not creditors of the other spouse). Likewise, upon the death of one spouse the other spouse succeeds (without the need for probate) to the sole ownership of all of the entireties property. Such property will not be subject to claims of creditors of the deceased spouse but it will, of course, be subject to claims against the survivor. Second, in some circumstances the ownership of property as tenants by the entireties may increase the estate taxes that may ultimately be payable with respect to such property.

Trusts ● In general, under Florida law, creditors may only seek satisfaction from trust property to the extent of the debtor's interest in it. For example, assets of a trust created by a debtor in which the debtor has not retained any beneficial interest or power of alteration, amendment or revocation would not be subject to attack by creditors of the debtor (assuming the trust was not created in a fraud upon those creditors). However, if the debtor retains the right to revoke the trust or has other rights in the trust such as the right to appoint the beneficiaries of the trust coupled with a retention of a life interest in trust income, creditors of the debtor will be able to avoid the trust entirely, because the debtor could easily do the same. On the other hand, if a debtor creates an irrevocable trust retaining solely the right to receive trust income for life, the creditors of the debtor are not able to seek

satisfaction from the trust assets, but they may attack the retained income interest of the debtor. Thus, although leaving the income therefrom subject to creditors, the use of an irrevocable trust with a retained right to income protects the trust assets from creditors' claims.

A spendthrift trust is a trust which contains a restraint on the voluntary and involuntary transfer of the interest of the beneficiary in the trust (but not upon transfers of trust property once distributed to the beneficiary). That is, the typical spendthrift bars the beneficiary from effectively pledging or assigning his or her interest in the trust.

As against creditors, a valid spendthrift trust prevents the creditor from "stepping into the debtor's shoes." For example, a creditor of an income-beneficiary of a spendthrift trust cannot compel the trust to make distributions directly to the creditor, but, rather, the creditor must wait until the trust makes distributions to the debtor-beneficiary and then the creditor may proceed against the beneficiary. Because the law recognizes the validity of spendthrift trusts, a debtor's interest in such a trust will be exempted property during a bankruptcy proceeding, and a debtor may procure a discharge of many of his or her debts in bankruptcy while retaining an interest in a spendthrift trust. In addition, even without using bankruptcy to obtain a discharge it is possible that a judgment creditor would not persist in proceeding against a debtor each time that the debtor receives a distribution from a trust. Unless the creditor knows that the beneficiary has received a trust distribution the beneficiary may be able to enjoy the proceeds prior to attachment thereof by the creditor.

The usefulness of the spendthrift trust is diminished by the legal doctrine which prohibits a person from establishing a valid spendthrift trust for himself or herself as beneficiary. However, it may be possible to establish a valid spendthrift trust for a friendly beneficiary, such as a child or other relative, who has a lower exposure to liabilities than the settlor and still retain the use of trust distributions.

It is also possible to utilize a discretionary trust to protect oneself from creditors. In a discretionary trust the beneficiaries are named, but the trustee has the discretion to make distributions to the beneficiaries, and neither the beneficiaries nor their creditors are able to force the trustee to make distributions. Thus, although a creditor can get his hands on any trust distributions actually made to the debtor-beneficiary, the creditor cannot force the trustee to make distributions. Unfortunately, however, Florida case law has upheld the validity of a continuing garnishment which would prohibit the trustee from making any distributions to or for the debtor-beneficiary by providing that any such distribution must instead be made to the creditor of the beneficiary. So, in the discretionary trust there is no opportunity for making distributions when creditors aren't looking. As with the spendthrift trust, property held in a discretionary trust will generally pass through a beneficiary's bankruptcy unscathed and after discharge of the debts the beneficiary could thereafter receive distributions free from judgment creditors' claims.

Exemptions ● Even if property is owned by a debtor it may be exempt from creditors' claims pursuant to one or more provisions of Florida law. Although the following discussion is not exhaustive, the major exemptions available to private practitioners are addressed.

Pension, and profit-sharing plans and IRAs. Pension and profit-sharing plans including Keogh (H.R. 10) plans and individual retirement accounts are extremely important assets of potential debtors (and juicy fruit for creditors). Until recently, under Florida law many debtors' interests in pension and profit-sharing plans and IRAs could not be viewed as safe from the grasp of creditors.

However, in 1987 the Florida legislature passed an exemption for certain retirement benefits. The new statute provides that "any money or other assets payable to a participant or beneficiary from, or any interest of a participant or beneficiary in, a retirement or profit-sharing plan that is qualified under S 401(a), S. 403(a), S. 403(b), S. 408, or S. 409 of the Internal Revenue Code of 1986, as amended, is exempt from all claims of creditors of the beneficiary or participant." Thus, the statute applies to any qualified stock bonus, pension, or profit-sharing plan, any qualified annuity plan, any individual retirement account, and any employee stock ownership plan (ESOP).

It is not clear whether the new law protects plan distributions once received by the debtor, and it is possible that once a plan makes a distribution to a beneficiary the distributed assets will be subject to the claims of creditors. However, the interest of a debtor in a plan that is protected will pass through bankruptcy intact, preserving the debtor's retirement security.

The new statute applies to proceedings filed on or after October 1, 1987.

Homestead. The Florida Constitution provides that each natural person is entitled to a homestead, i.e., permanent residence, of up to one-half acre within a municipality or 160 acres in nonmunicipal areas, together with $1,000 of personal property, that is exempt from creditors' claims (except for taxes, obligations incurred to purchase, improve, or repair the homestead or for labor performed on it). The homestead exemption protects only the real property and certain structures and fixtures on the property but there is no limitation upon the value of the exempted homestead. Furniture within the home located on the homestead in excess of the $1,000 personal property exemption is not part of the homestead and can be

subjected to a forced sale. Curiously, as it pertains to lands outside the limits of an incorporated city or town the homestead exemption includes up to 160 acres of land (which is not reduced if the land is subsequently brought within a municipality). Inside a municipality the homestead exemption is limited to one-half acre of property encompassing the residence. The personal property exemption is cumulative to the other exemptions to be discussed later. Pursuant to the 1985 Constitutional revision, both a husband and wife may now claim a $1,000 personal property exemption and, if separated and living apart, both could have an exempt homestead.

Florida law permits a homesteader to designate his or her homestead by filing a document in the county real property records. The failure to designate does not result in a waiver of a right to claim the exemption and the designation does not establish the validity of the exemption. However, the designation is a factor which may be taken into account in determining the applicability of the exemption, i.e., which residence is the permanent residence when a debtor owns more than one residence. A homesteader can designate the property claimed as homestead prior to (pre-levy) or after (post-levy) the time a creditor attempts to obtain the forced sale of the property. Although no real legal benefit would be derived from the filing of a pre-levy designation of homestead (because in all cases the Constitution prohibits the *effective* forced sale of homestead), as a practical matter it may be wise to file a pre-levy designation of homestead. (Although a Florida judge once observed with respect to the pre-levy filing that "absent notice that we are in need of this protection against forced sale of our homes, few of us are likely to travel down to the courthouse and make a [homestead] designation just in case it might prove handy someday".)

The pre-levy designation must be signed and must contain a description of the real property claimed to be exempt and a declaration that the described property is the homestead of the party for whose benfit the claim is made. The designation should be recorded with the Clerk of the Circuit Court for the county in which the property is located.

There is no pre-levy designation of exempt personal property. The designation and selection of exempt personal property is made by the debtor after the property has been seized under legal process.

Wages or earnings of head of family. Also exempt from the claims of creditors under Florida law are "money or other things due to any person who is the head of a family residing in this state, when the money or other thing is due for personal labor or services of such person." Thus, in order to utilize the wages exemption a debtor must prove that he or she is a resident of Florida and the head of a family. The Supreme Court of Florida has held the exemption to cover compensation of professionals, and has recognized that there is no dollar limitation upon the amount of compensation that may be protected.

The wages exemption covers wages not yet paid to a debtor and also "any wages deposited in any bank account maintained by the debtor when said funds can be traced and properly identified as wages." Thus, it is advisable to establish a "wages-only" account into which deposits of wages are made in such fashion that records showing the source of deposits are maintained. In addition, because of the exempt status of wages in this account, to the extent financially feasible other, nonexempt, income of the potential debtor should be utilized in the payment of day-to-day expenses, preserving the integrity of the wages-only account as a safe haven for future needs.

The wage exemption law does not provide a definition of the term "bank account" and it is not at all clear what constitutes a "bank" or an "account" under this provision (e.g., what about a savings and loan institution or credit union). In addition, it is unclear whether the wage earner exemption covers earnings on funds in a wages-only account or only the principal amount of wages deposited. If the wage-earner is married it might thus be advisable to establish the wages-only account in the name of the tenancy by the entireties and obtain the immunity afforded that type of tenancy on all amounts in the account. An unmarried wage-earner should probably periodically remove earnings from the wages-only account and spend them or invest them in other exempt property.

Life insurance. Two important exemptions apply to life insurance policies of Florida residents. The first provides that when a Florida resident dies, insurance on his or her life inures exclusively to the benefit of the beneficiary of the policy and the proceeds thereof are exempt from claims of creditors of the insured unless the insurance policy or a valid assignment provides otherwise. However, if the insurance policy designates the estate of the insured as the beneficiary then creditors of the decedent will be able to attack the proceeds of the insurance in the estate.

The second, more important, exemption applicable to insurance provides that the cash surrender value of life insurance issued upon the life of a Florida resident is exempt from claims of creditors of the insured or the beneficiary unless the policy was issued for the benefit of the creditors.

In addition to exempting the cash surrender value of insurance proceeds, Florida law exempts the proceeds of annuity contracts from creditors of the annuitant or beneficiary of the annuity contract.

The life insurance cash-surrender value and annuity proceeds exemptions do not apply to proceeds in the hands of the debtor. That is, the exemptions only apply to prevent creditors from attacking the insurance policy or annuity agreement; the creditor may proceed against life insurance proceeds or annuity

proceeds once in the hands of the debtor, and, for example, deposited in a bank account. However, during bankruptcy proceedings the insurance policy and annuity contract will be exempt and a debtor may obtain a discharge and emerge owning the policy or contract free from creditors' claims.

In addition to the foregoing exemptions, disability income benefits payable under any type of insurance policy or contract are exempt from the claims of creditors unless the policy was enacted for the benefit of such creditors. Unlike the exemption for life insurance proceeds, the exemption of disability income benefits applies to exempt from claims of creditors proceeds of such policies that have been deposited in a segregated savings account.

Other exceptions. In 1987 the Florida legislature also enacted an exemption covering the debtor's right to receive social security benefits, unemployment compensation, veteran's benefits, and alimony, and support or separate maintenance payments to the extent reasonably necessary for the support of the debtor and any dependents of the debtor. This exemption applies in bankruptcy proceedings filed on or after October 1, 1987.

Fraudulent transfers ● Under the law of fraudulent conveyances a fraud upon creditors occurs when a debtor intends to prevent his or her creditors from recovering their debts by withdrawing his or her property from their reach. If a creditor can show that a debtor transferred property with an intent to prevent the creditor from attacking that property, Florida law may allow the creditor to avoid the transfer, i.e., to act as if the transfer had not taken place, and proceed against the property as if it were still owned by the debtor.

In general, to avoid a transfer a creditor must show that the debtor's transfer was intended to be a fraud upon existing creditors who, at the time of the transfer, the debtor desired to prevent, hinder or delay in the satisfaction of their claims. It should be noted that the Florida courts have consistently held that contingent creditors are as fully protected against fraudulent transfers as are holders of absolute claims. For example, if a negligent act has already happened but has not yet been discovered or brought to judgment, a creditor may nevertheless exist for purposes of the law of fraudulent conveyances. Thus it is possible that a transfer may be avoided as a fraud upon creditors even though at the time of transfer no liability was known to have existed.

In addition, the fraudulent transfer doctrine enables subsequent creditors to avoid transfers made prior to the time the creditor's claim arose if the creditor can show that the transfer was made by the debtor in contemplation of incurring future debts with fraudulent intent to hinder their satisfaction. In Hummel v. Harrington the Florida Supreme Court noted that the determination whether a conveyance is fraudulent as to subsequent creditors depends on "whether it was made in contemplation of future debts, or to secure the debtor a retreat in the event of probable pecuniary disaster in a hazardous business in which he proposes to embark. To bring the transfer within this rule it must be executed with the intent and design to defraud those who should thereafter become his creditors, the debtor proposing to throw the hazards of the business in which he is about to engage upon others, instead of honestly holding his means subject to the chance of adverse results incident to all business enterprises." Although the language of Hummel, a 1929 case, is broad enough to question whether all transfers by a physician constitute fradulent transfers, to date no court has so held.

It should be noted that the legislature has adopted, effective January 1, 1988, the provisions of the Uniform Fraudulent Transfer Act. Although the Act is generally consistent with the above discussion, the new law may broaden the ability of creditors to avoid "fraudulent" transfers.

Bankruptcy ● A physician who has been subjected to a multimillion dollar judgment may suffer the financial burden of that judgment for years to come. However, pursuant to the provisions of the United States Bankruptcy Code debtors may undergo personal bankruptcy, obtain a judgment discharging most debts (including judgments for tort claims) and exempting all of the property previously discussed and obtain a fresh start free from the claims of creditors with significant assets still available. All property that is exempt under Florida law may survive a bankruptcy unscathed. Thus, at the very least a physician should be able to maintain a valuable homestead, a wages-only account of virtually limitless size, a life-insurance policy with a large cash surrender value, a large annuity contract, and whatever else may be owned by the professional as a tenancy by the entireties. Although further discussion of bankruptcy is beyond the scope of this article, in the face of extremely large judgments bankruptcy must be viewed as a favorable option rather than as something to be avoided.

Planning ● While planning to insulate one's assets from liabilities it is important to consider not only the law of creditors' rights but also tax law, professional regulatory law, family law, and the economics of the plan. Because of the extremely broad analysis required, what is a good plan for one person may not be good for another, and generalization can be dangerous. Before undertaking any steps discussed in this article one should seek competent advice from a qualified source.

● Mr. Raymond, P.O. Box 3888, West Palm Beach, FL 33402

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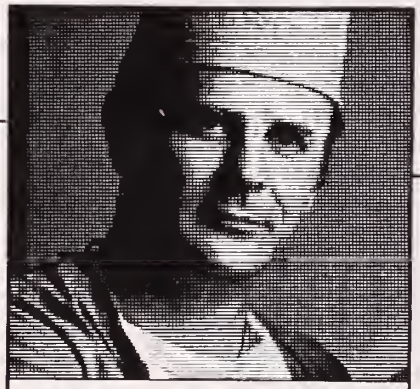

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Musings on "The Rise and Fall of the Great Powers"

Paul Kennedy in his new work, "The Rise and Fall of the Great Powers," peers at history as a dynamic cinema of economic flux rather than interpreting it in the usual politico-military style of classic historians. Professor Kennedy is J. Richardson Dilworth Professor of History at Yale University. His book, in which he blatantly states that the United States has passed its economic zenith and has started a downward slide into economic dessication, has attracted the attention of a wide audience since its publication in January and now has seized a position near the top of the best seller list. His study covers a vast historical and macroeconomic expanse that extends from 1500 until the mid-1980s. Although its messages are not immediately applicable to the microeconomic problems of Florida physicians, an in-depth review will reward the reader with a fresh, rich and broad grasp of the interlinkages between economic status, world power, and the relative freedom and social advantages that accrue to the citizenry of economically ascending nations versus the unpleasantries that befall the occupants of declining states.

Stream of economic changes ● Kennedy's central thesis is that history is a stream of economic change and technological development that flows at unpredictable rates over various parts of the globe. Alterations in the sociologic structures of nations, their political systems, military power, and the relative positions of nations and empires in the global sphere follow the technologic and economic evolutions that precede. While economic prosperity may not immediately translate into military potency, e.g., modern day Japan, the major wars of the past five centuries have always been won by the party that possessed the greatest economic and technologic resources. The shifts in the balance of power among nations has always followed military successes that were nurtured by economic superiority. The strategic intelligence of military and political leaders, geography, climate and good fortune also plays a role, of course, in the military outcomes of history but these factors are minor determinants when compared to the overriding importance of technologic and economic prowess on the outcome of war and the relative stature of nations in the power lineup of national states.

A corollary to Kennedy's thesis is that great powers expand their geographic and military influence until they become overextended. Expansion plus the logarithmic increases in the cost of military technology that occur with time require that a greater proportion of their national productivity be devoted to sustaining their supremacy. This necessarily reduces the amount of national income that can be invested in other, more productive, endeavors in which the society should be involved in order to maintain a vigorous rate of economic growth. Economic fatigue sets in, stagnation appears, and decline begins. Military and political decay always follows economic decline.

Kennedy supports his interpretation of history with a rich lather of detail and fine writing that reviews world history since 1500. The 16th century was the time at which European nations began their rise to international dominance and the time of onset of a parallel enfeeblement in the Chinese and Muslim empires. China had been vigorous since the 10th and 11th centuries. The nation had invented gunpowder and printing, developed an iron industry that was superior to that of England's in the mid-18th century, had educated a large proportion of its population that served as its bureaucrats, had developed sophisticated agriculture and canal systems of transportation at home and had established a commercial navy that stretched as far as the Near East in its trading ventures. A military threat to mainland China from the Monguls caused the rulers to disband the naval and commercial sea activity, mothball the fleet, and turn inward. The country slowly declined for the next six centuries.

The Muslim empire also reached its peak in the 15th century surpassing Europe both culturally and technologically. The people developed concepts of public health and medicine, mathematics and cartography centuries before the concepts were adopted by Europeans. By 1500 the Ottoman Empire had overreached its resources — covering the entire Near East, northern Africa, parts of southern Europe, and extending to the Aegean and Crimean areas. The empire was also highly centralized and suffered from the incompetence of several very powerful, single rulers. The

costs of administering and defending such an extended empire ultimately exhausted its resources and ultimately destroyed its vitality as a major world force.

Portugal and Spain were the first great European nations. Portugal's rise was fostered by the naval technology inspired by Prince Henry the Navigator and the advances made in shipbuilding, cartography and the raw courage of the sailors and captains who dared to strike out over the vast ocean expanses. Spain followed the Portuguese and both countries prospered from their worldwide trade and exploitation of Asia and the Americas. Spain ultimately dominated the New World territories and militarily expanded its influence over a major share of Europe. However, it also overextended itself; like the present day United States, it committed itself to military responsibilities that it could not support. It relied on deficit financing, foreign borrowing, and failed to tax its own citizens enough to pay for its militarism. Ultimately, the economic burden crushed it.

Britain, Germany, the United States and Russia have all followed the same track: industrial development, rise of a prominent middle class, military development and political expansion. Only when a country has overcommitted itself militarily has its economic growth been stifled.

Kennedy feels that modern day Russia is in a severe stage of decline, even though it possesses awesome military prowess. Its military strength has been developed by sacrificing the rest of its economy, such as agriculture, nonmilitary technology, and all other areas of human endeavor. Even medicine and public health have been permitted to decay. Sanitation and public hygiene are deteriorating. Russia is the only industrialized nation in which the infant mortality rate is increasing. It is now three times that of the United States. The average life expectancy has fallen to 60 — which is six years less than that which prevailed in the 1960s and contrasts with the current life expectancy of 74 for the American male. This flawed medical system exists despite the presence of a very large population of physicians in the Soviet Union.

Kennedy feels that the economic supremacy of the United States has faded. Japan probably enjoys a greater per capital income. He predicts that the Pacific Basin countries, particularly China, will fluorish during the next half century while the USA and Europe continue to sink into deeper states of decrepitude. He does admit that the leaders of the United States have the opportunity, now, of reversing the current debilitation by the adoption of responsible financial policies. However, he also realizes that human nature and politics are such that little chance exists for the application of the proper remedies necessary to reverse this county's current infirmities.

Useful lessons ● Perhaps it is ludicrous to attempt to extract lessons useful to the picopicture of our everyday medical practices from such a broad panoramic display of human history. Nevertheless I will try to squeeze driblets of wisdom that might be appropriate to our daily professional lives from Kennedy's work.

The first obvious lesson is that the economic well-being of physicians and the medical field, in general, has sprung from the technological breakthroughs and advances in our knowledge base that have occurred during the past 50 years. Medicine, as a component of society, shares some resemblances to nation-states and can expect its fortunes to follow the parabolic fates of nations. This has enhanced the economic stature of physicians and has provided them with an influence upon society that far exceeds the influence that might be expected from their numbers alone. Furthermore, medicine like the remainder of human society has rewarded the technologically proficient doctor more so than the purely knowledgeable physician. However, the cost of technological advancement, like the cost of military weaponry, is outstripping the ability of society to sustain further expense

In previous articles I have written how medical care has contributed to the economic well-being of the United States in that it has reduced the total cost of illness, i.e., the cost both of medical care and of loss earnings. However, if the cost of future medical care continues to exceed the economic growth rate of this country then medicine will bankrupt itself; it will consume more resources than it returns to the citizenry. Medicine will become an economically degenerate profession; its physicians will suffer loss of the prestige and influence they have enjoyed for the past half-century — in the same fashion that nations have lost their position in the global power structure by allowing the cost of sustaining their position to exceed the ability of the country to maintain that status.

How will physicians perpetuate the ascendancy of medicine in the structure of American society or how will they prevent or decelerate its demise? They will have to become aware of the collective effect of their actions on the economic well-being of the entire nation. Unfortunately the information needed to measure the entirety of medicine's effects on the finances of American society in unavailable. Collection, collation and analysis of such data have become important and our leaders must find the means to gather this information.

Secondly, the economic costs of applying a new technology must be balanced against the economic benefit it will provide. Ways to truncate the costs of new technology will also have to be developed if medicine is to remain cost effective.

Third, doctors may be forced to ration the use of high cost medical care in those patients who most likely will not benefit from it such as the terminally ill or the deformed neonate. This does not mean that the patient need be abandoned or not comforted; it does mean that highly expensive efforts to preserve

and prolong a hopeless situation be ended early. This last concept is one that is currently debated intensely and one that contradicts our ethical upbringing; furthermore it threatens to sunder a cord of ethical tradition that stretches back thousands of years. This topic must be addressed and a reasonable solution applied since such profligate use of medical technology consumes a huge share of the cost of medical care.

Fourth, we must analyze, in an economic framework, each of the diagnostic and therapeutic maneuvers we deploy in our daily practices and determine if our actions are truly cost effective. We should not await the millenium for answers to the economic benefits of our daily routine; the aggregate wisdom and experience of a half million doctors will provide us some insights into the economic worth of what we do.

Fifth, since medicine is so expensive we must expunge unseen elements of cost from practice. If the United States consumes 11% of its gross national product on health care versus 99% for Germany and Sweden, we must ask what accounts for the difference. One obvious answer is the convoluted tort system in the United States. How much does our tort system and its attendant defensive medical practices add to the cost of medical care? One percent, two percent or three percent of the GNP? Nobody seems to know but this should be studied in a prospective fashion.

Sixth, physicians might benefit from wielding some intellectual influence upon the educational realm of business and management. Forty percent of our high school seniors who are entering college in the fall are pursuing educational programs in business, economics or management. How many of us have writen to our universities and colleges and encouraged them to develop new programs in the management of medicine. If medicine commands such a large share of the national economy, it behooves these schools to foster new research into and offer studies on the management of medicine. I am tired of hearing that medicine is so labor intensive that cost savings are impossible to achieve. I am certain there are engineering and managerial solutions to our current high cost health delivery problems. Let us find them. Let us encourage and institute relationships with the universities to do so. Medical economics will always be a neglected stepchild of medical schools; it must become an integral part of the business and management curricula.

It is difficult to remain sanguine about the future after reading Kennedy's book. As one thinks about the current situation in medicine in which the profession is under attack on so many fronts, it stretches one's capabilities to remain optimistic. Nevertheless, those individuals who remain technologically adroit, creative and adaptive will probably survive in a vigorous fashion.

Jacques R. Caldwell, M.D.
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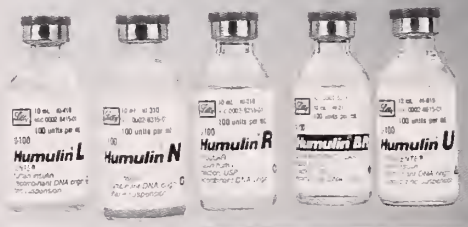

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NOTES & NEWS

Dr. Baker Receives Distinguished Service to Humanity Award

James L. Baker, M.D., Winter Park plastic and reconstructive surgeon, received the Distinguished Service to Humanity Award from the Florida Southern College Alumni Association on Friday, March 18.

Dr. Baker was selected to receive this award for his contribution to the betterment of mankind through his many years of dedicated service in the field of medicine. "Of all the awards I've received during my career," said Dr. Baker, "this one means the most to me because Florida Southern College gave me the education necessary to achieve my life's goal of becoming a physician."

Dr. Baker is world-renowned for his contributions to the field of plastic surgery, and recently taught at the 22nd Annual Cosmetic Surgery Symposium in Miami.

USF Diabetes Center Seeks Volunteers

The University of South Florida is looking for 25 diabetic volunteers to take part in a five-year nationwide study aimed at finding a more effective treatment for diabetes complications.

Sponsored by the National Institutes of Health, the Diabetes Control and Complications Trial is being conducted at 27 medical centers throughout the country. The USF College of Medicine is in the only center in Florida and one of only three in the Southeast chosen for the trial.

"We're comparing two different insulin therapies to see if one or the other is more effective in slowing down or preventing the complications of diabetes," said Nancy Grove, coordinator for the USF trial.

Nationally, the study will involve some 1,400 diabetic patients.

"This is the biggest clinical research study ever done on diabetes, and one of the largest ever conducted on any disease," Ms. Grove said.

To be eligible, volunteers must be between 13 and 39 years old. They must have had insulin-dependent diabetes for at least one year but not more than five years. Volunteers who are accepted into the trial will get all their insulin and diabetes-related supplies and medical care free for the course of the trial.

Volunteers who live outside Tampa Bay area must be available to come to Tampa once a month during the trial.

One group of volunteers, the "standard group," will use conventional diabetes treatment, taking one or two insulin shots a day and monitoring their blood or urine.

The other group, the "experimental group," will take three or four insulin injections daily or use an insulin pump and monitor their blood four times a day.

Ms. Grove emphasized that the safety of all participants is ensured.

"All data are sent to a coordinating center," she said. "While the study is going on, if they find out that one therapy is better, or one is unsafe, then the study would be terminated."

For more information call the USF Diabetes Center at 974-4360.

Marijuana Use May Be Linked to Immune System Deficiencies

Medical researchers at the University of South Florida are finding that marijuana may have dramatically harmful effects on the body's immune system and may be a factor in the disease AIDS.

Herman Friedman, M.D., professor and chairman of the department of microbiology and immunology at the USF College of Medicine, said in an article in the Spring issue of USF Magazine that when purified THC (tetrahydrocannabinol, the main psychoactive component in marijuana) is added to any of their model systems in the cells of mice, the immune response system of the mice becomes suppressed. Dr. Friedman said it is this breakdown of the immune system that makes AIDS so deadly.

Thomas Klein, M.D., co-principal investigator in the study, said that AIDS patients suffer from chronic infections that eventually kill them because they don't have this immune response to fight infection.

"You observe the condition of AIDS patients who are without those responding cells and you can see

the importance of the immune response," Dr. Klein said.

The research team is in the fourth year of an eight-year study. Although initial research was done with mice cells, their study now includes direct injections into mice with doses proportionately the same as those used in monkeys.

"We are using doses which are achievable in monkeys and man," Dr. Klein said. "The levels are similar to what is found in the blood of heavy users of marijuana."

Steven Specter, M.D., also from the USF microbiology and immunology department, has begun a similar study using human cells. His research is limited to direct treatment of cell cultures. So far his findings are the same as those of Drs. Klein and Friedman.

The researchers hope that their studies will add to the understanding of the basic drug-cell interaction and that further studies will determine how dangerous marijuana actually is to the human immune system.

Scientific Exhibit Space Available

Arrange for your space in the scientific exhibits at FMA's 114th Annual Meeting in Hollywood, Florida. Approximately 2,000 physicians spouses and guests are expected to attend this year's meeting.

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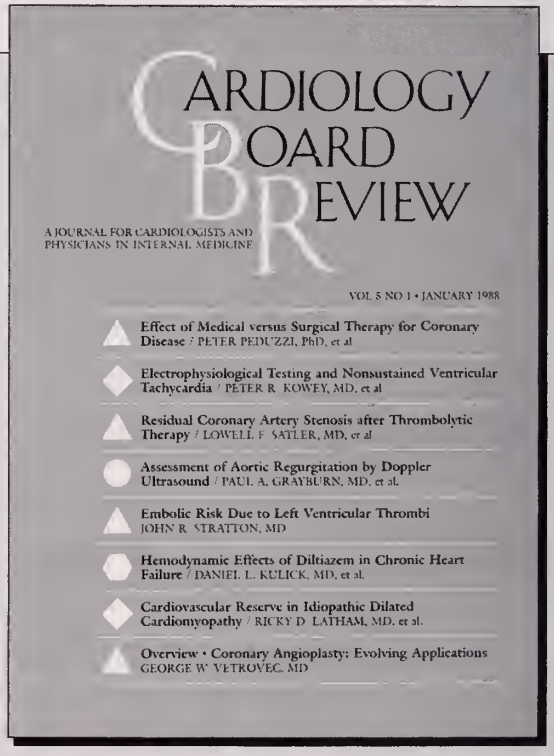

*Journals reviewed include: *Circulation, American Heart Journal, Journal of the American College of Cardiology, British Heart Journal, Chest, The American Journal of Cardiology, The New England Journal of Medicine, Annals of Internal Medicine, American Journal of Medicine*, and *The Journal of the American Medical Association*.

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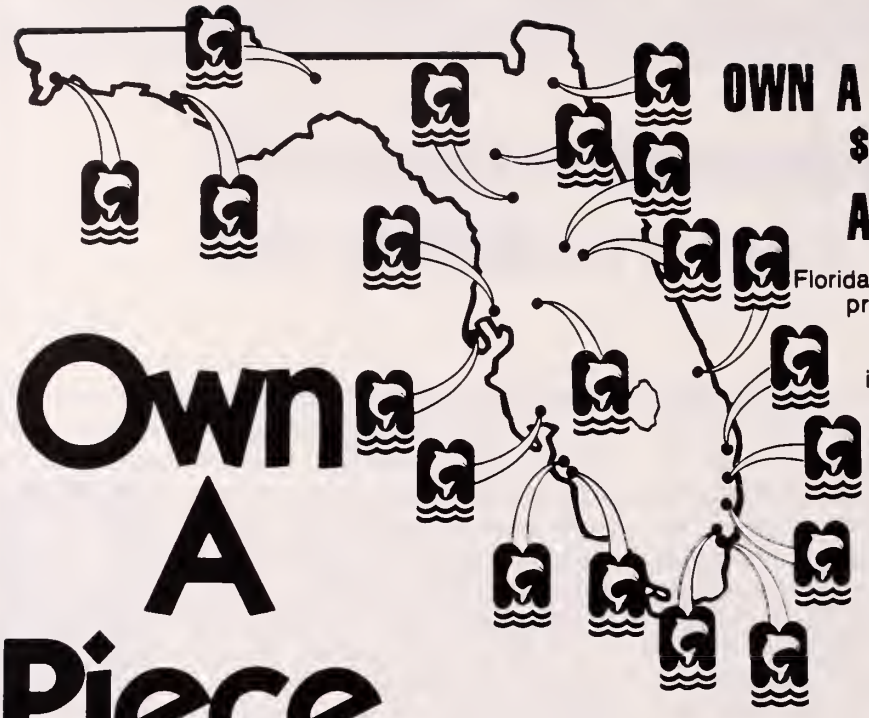
Medical students of today will become the leaders in organized medicine of tomorrow. The Florida Medical Association recognizing the need to actively involve medical students in organized medicine established a Medical Student Section (MSS) in September 1986. With the guidance of the FMA leadership and support of local county medical societies, medical student membership has grown sixfold to include over 300 members statewide. These students will continue participating in organized medicine long after graduation day. An informal survey conducted at the state's three medical schools revealed more than two-thirds of graduating senior medical students plan to pursue the practice of medicine within Florida.

The medical school curriculum provides an excellent base of knowledge, enabling the student to understand illness, establish a diagnosis and decide on appropriate therapy. Crucial issues such as the rising cost of malpractice insurance, community programs and third party payment systems receive very little attention.

One of the main goals of the FMA-MSS is to encourage medical students to become informed and involved in events occurring in the medical arena. The outcome of the upcoming legislative session will affect the future of medical practice. Medical students need to become involved now. Student groups are actively involved in helping to direct the future of medicine through membership on many FMA committees, legislative lobbying efforts and participation in the current constitutional amendment campaign.

The Medical Student Section is organized, enthusiastic and looking forward to continued involvement. I would encourage the FMA membership to incorporate the medical students and residents in future campaigns since it will take the combined efforts of students, physicians and patients to develop a feasible system for the challenging times for medicine which lie ahead.

Martin A. Kubiet
University of Florida College of Medicine
Gainesville
Student Member
FMA Board of Govenors



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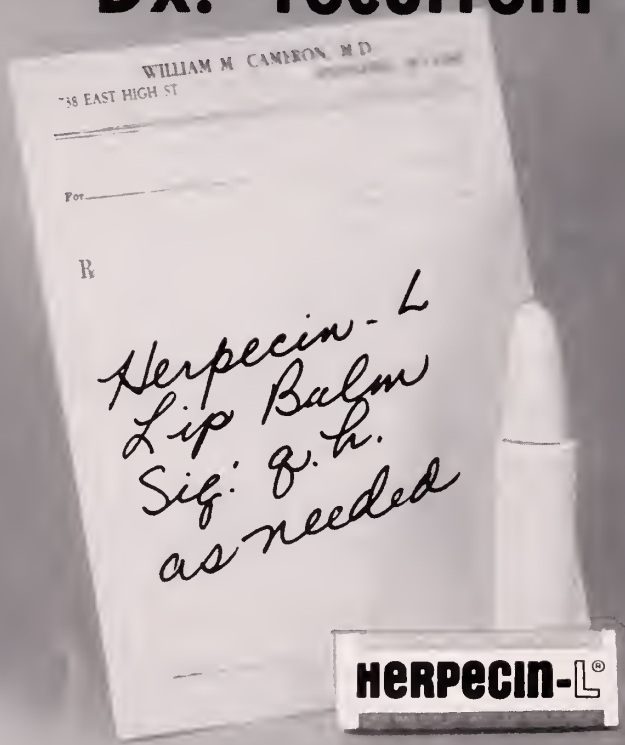

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Too Many Internists, Or Not Enough?

It has been predicted that by 1998, that is, in about decade, there will be 141,000 active internists in the United States. In 1985 there were 91,000, an increase from 64,000 in 1978.* For many, perhaps most internists, this may be cause for alarm, but it could also be viewed as an unprecedented opportunity to find new expressions and to develop new dimensions for internal medicine. It may not be too early to begin thinking of the possibilities.

Perhaps one might begin by looking at internal medicine in some kind of perspective. Our specialty has the heritage of Osler and the art and skills of diagnosis, prognosis and caring for patients that so clearly characterized internal medicine in the early part of this century. But now with the developments in biomedical science, internal medicine finds itself a focal point for the new science as well as the old art of medicine.

Only Undifferentiated Specialty

When one thinks about it, internal medicine may also be viewed as a kind of ground substance that pervades every branch of medicine in the same way that its art and science applies to every aspect of a patient. In this view, internists are actually the only true generalists; or one might say, internal medicine is the only truly undifferentiated specialty in all of medicine. Yet, there are now many subspecialties within internal medicine; indeed the whole medical profession is quite sharply divided into specialties and subspecialties. But, to a greater or lesser extent, each of them shares in the ground substance of broad-based internal medicine, because the art and science are basically one throughout all of medicine, and each patient that is served is actually an undivided, whole person. Broad-based internal medicine therefore emerges as truly something special.

From this it follows that internists themselves must also be something special. Most internists do main devoted to the art. They listen and spend time with their patients. But their specialty is also now at the frontiers of modern medical science, and so today they bring this new scientific knowledge to their care of patients. But for the purposes of this discussion, internists are also widely known for their interest and well-honed skills as problem solvers, especially when cases are complex and diagnosis or management is difficult.

Beyond Patient Care

For this role internist have developed very specific problem-solving skills that in a broad sense are generic to solving complex problems in almost any aspect of health care. The process is objective and well adapted to making decisions in rapidly changing situations, especially when there is insufficient information, and the process allows for changing course quickly when more information or data become available. It seems obvious but worth noting that health care has many rapidly changing situations amendable to this approach, and it is to their credit that many internists have already begin to apply their skills in situations beyond patient care.

So, just as general internal medicine is an essential ingredient in all medical care specialties, just as it has budded off many subspecialties of its own and just as, through ASIM, it has begun to use its special problem-solving training and skills to address difficult social, economic and political problems in health care, this undifferentiated specialty now has the capability and opportunity to provide needed leadership to work on almost any problem that relates to health or health care.

It speaks from the vantage point of its knowledge of medical science, the ancient art and its hands-on experience in patient care. While the use of this training and expertise is actually a responsibility of the whole of medicine, internal medicine has refined these skills. Internists are in good position to exercise leadership and to move into the vacuums in the medical profession's current approach to so many unsolved problems.

Doctor for the System

Will there be too many active internists in 1998? Perhaps so. But this may well depend on how proactive internists have become by then, and how well they see internal medicine filling professional gaps. The specialty can build upon its position as the ground substance in the art and science of all of medicine and continue to bud off subspecialties,

* P.R. Kletke, M.K. Schleiter, A.R. Tarlow. "Changes in the Supply of Internists: The Internal Medicine Population from 1978 to 1998." *Annals of Internal Medicine 107(1987):93-100.*

rooted in internal medicine, including subspecialties that can deal with health care delivery and other aspects of the health care enterprise in the same way that subspecialties have been developed to deal with problems within internal medicine itself.

Looked upon in this way, there just might be enough to do to keep all 141,000 active internists as busy and productive in 1998 as they are today. Maybe there will not even be enough internists to do what will need to be done!

Malcolm S. Watts, M.D.

Reprinted with permission from *The Internist*, March 1988.

1986 Legislation Could Change the Way You Practice Medicine

Late in 1986, without fanfare, Congress passed, and the President signed, a bill into law that will ultimately have as great or greater impact on the manner in which we practice medicine than all the budget bills dealing with reimbursement methodologies. I am referring to the Health Care Quality Improvement Act. If not modifed, it can be an ominous piece of legislation.

One of the most significant things that we do as physicians on medical staffs, or as members of professional associations, or as members of large physician groups such as IPAs or HMOs, is to periodically review each other in an effort to assure high standards of patient care. In California, we have excellent confidentiality statutes that protect from discoverability those involved in appropriate peer review.

However, as a result of the *Patrick* case in Oregon, the confidentiality and discoverability of the proceedings were challenged in a federal court case which held that federal antitrust laws could be applied to good faith medical staff or other peer review evaluations, whether in the credentialing process or in the periodic review for continuing privileges at a health facility. Subsequently, a United States Circuit Court of Appeal declared that good faith proceedings are not subject to federal antitrust statutes. This case is now before the United States Supreme Court which is expected to render its opinion in the near future.

However, reacting to the implications of this case, Congress decided to develop a law that would protect peer review proceedings from antitrust discoverability. It promptly created the Health Care Quality Improvement Act. Despite its lofty purpose, this act — this law — does a lot more than offer protection. It creates potential problems that could have far-reaching consequences for every physician in this country.

First — and this is the good part — it creates a sound mechanism for protection against federal antitrust violation as physician review, for purposes of credentialing, privileging or appropriate peer review evaluation, is done in clearly prescribed procedures. For the physician who may question the proceedings or the outcome of such proceedings, provision is made for appropriate hearings and evaluation processes including clear due process; the right to have an attorney represent the physician in any hearing process; having all appropriate factual material presented to the physician in question; having a hearing officer who is not in potential economic competition with the physician; and having all decisions based clearly on the facts presented. This is a far cry from the initial regulations presented for the PRO deliberations, and represents a triumph for medicine.

The second, and most far-reaching part of the act, is the reporting mechanism that has been put into place. The act calls for a federal clearinghouse to receive data from all state medical boards on any adverse action that has been taken against a physician. This includes any change in privileges at a hospital, which can be interpreted as a lowering of the amount of privileges for over 30 days, and any refusal of admittance to a medical staff or removal therefrom. This reporting also applied to HMOs, PPOs, large clinics with organized review procedures and organized medical societies such a LACMA and the CMA.

The law also mandates that any action taken against an individual physician by a state medical board, or any action taken by a PRO based upon review of quality of care must be reported. Furthermore, and most horrifically, the law mandates the reporting of each professional liability settlement, whether it be in court or out of court, and no matter the amount — even if it is for just one dollar.

The insidious reporting mechanism required by this law, however, has not gone into effect since Congress — in its inimitable way of doing things — has not appropriated the funding to start the physican data bank. Not only did the legislators not fund it in 1986, they overlooked it in the recently-passed 1987 budget. Also, they've informed the appropriate implementing authorities that they are not authorized to move funds

from other sectors to get the reporting program going. Thus, the earliest the data bank can get started would be at the end of this year — after the 1988 budget is settled. In all probability it will become reality in 1989, but it *will become a reality* — make no mistake about that.

Full implementation of the law presents a potential nightmare. First, who has access to this data? The law clearly states that hospitals must access the data when physicians make initial application to a medical staff and recheck at least once every two years thereafter on each physician. If a hospital does not access the data, the law will presume that said hospital had knowledge of said data without access should there be any adverse proceeding in the future. The law also gives appropriate licensing boards access to the data, as well as to other organizations of physicians (such as LACMA in its credentialing process for membership) and to the individual physician who may wish to review his record.

Initially, the law would have allowed any member of the public to have access, including professional liability attorneys. But this dire loophole was closed by recently-passed legislation. However, it becomes clear that the hospital medical staff will have to look carefully at this data in its reprivileging and recredentialing process. Routine reappointment to a medical staff will surely become a thing of the past.

Furthermore, the law has been interpreted by representatives of the government to mean that any diminution of privileges will be subject to report. Even a physician who voluntarily gives up a privilege which he's had but has not used in recent years, such as a family practitioner deciding not to do OB, or a general surgeon deciding not to do chest surgery.

Certainly it is appropriate to require reporting of loss of privileges because of quality diminution. But it is highly inappropriate to report a lessening of privileges when a dedicated physician realizes he has not kept up his skills in a certain defined procedure and volunteers to take it off his privilege card in the name of quality assurance. Reporting that decision by a conscientious physician is patently unfair and its requirement must be removed from law.

Furthermore, the law does not protect the confidentiality of the physician who reports a quality concern to the appropriate body of the medical staff. It protects the committee charged with reviewing any quality charge and assures all subsequent due process hearing requirements. But the poor guy who pointed out the problem in the first place is not protected.

The law provides immunity only in review matters relating to physicians and not to other health care providers such as podiatrists, psychologists or other allied health professionals. This omission makes a mockery of the traditional role of hospital medical staffs in maintaining the quality of care in hospitals.

The AMA in 1983 adopted a report clearly stating that the hospital medical staff and its physician members have a clear role in making sure that allied health professionals are monitored by the medical staff for quality. If the law goes into effect as currently written, physician members of a medical staff will certainly not want to participate in any review of nonphysicians. Therefore, this law could totally change the relationship we now have with allied health practitioners.

Another bothersome provision of the law is that it has been modified so that a "user fee" will be charged to those accessing the data bank. This is fine as long as it is clearly stated that the amount of the user fee is based upon the cost of retrieving the requested data and appropriate maintenance of the program. It should not be used as a source of revenue for outside activities by whichever organization finally gets the contract. The user fee must be carefully monitored for I have no doubt that it will be passed onto physicians applying for hospital privileges, or to a hospital medical staff, thus potentially creating huge application fees to affiliate with a medical staff.

But perhaps my greatest concern is the professional liability reporting requirement. Reporting every settlement no matter how small will make physicians reluctant to settle anything even though most professional liability cases are found to have no merit (81% in California). Therefore, the so-called nuisance cases will end up in court and the net result of all this could well be substantial increases in professional liability premiums. Here in California, only judgments or settlements in excess of $30,000 are reportable to the State Medical Board, thus eliminating the nuisance suit report. That of course becomes null and void as soon as the federal data bank becomes operable. Alas the State Medical Board then becomes the agency funneling data to the feds on a periodic basis.

There is time to remove the clinkers from this well-intended law. Since appropriations will not be forthcoming for another year, a concerted effort should be made to close the perceived loopholes and to eliminate the objectional passages. I am happy to report the CMA legal counsel is already looking into it.

This law is another example of government rushing into something without thinking about the long-term implications of their actions. It is indeed appropriate to have federal antitrust protections for physicians involved in peer review proceedings. I have no problems with a data bank that reports substandard care by physicians. But I do have concerns about a law which can snag honorable and first-rate physicians — practicing high quality medicine — into situations which could cost them endless hours of anguish and exorbitant sums of money merely to clear their names.

Gary F. Krieger, M.D.

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BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

Prostitution in Medieval Society

by Leah L. Otis, 240 pages, The University of Chicago Press, Chicago, Ill., 1987.

Prostitution in Medieval Society is an exceptionally fine study of a relatively obscure subject. The author has done admirable research and interprets in an effective, and yet, appropriately modest manner.

The descriptive discussion of this slim volume may be summarized succinctly. The High Middle Ages (12th and 13th centuries) witnessed a revived interest in the subject of prostitution evidenced by the author's principal sources, the Languedoc Towns. The prostitute was regarded as a necessary evil and obliged to remove herself from respectable neighborhoods and usually even to encamp outside the town's walls. The 13th and 14th centuries proved transitional and more accepting toward prostitutes who were allowed to live on special streets or protected houses often near the centers of the city. The brothels even came to be municipally operated with the prostitutes, though often immured and forced to wear special dress, enjoying legal protection, particularly in cases of rape.

This seemingly laxity changed in the 16th century with the coming of higher morals for males, reinforced by Luther, Calvin and the Catholic Reformation. And so prostitution lost its political protection and its institutionalized system of the earlier centuries was destroyed. The author makes a genuine contribution to the history of ideas in showing that moral reform preceded the Reformation and Counter Reformation. But why did it do so?

While she is to be felicitated for her hesitance to draw conclusions when all the research is not in, I think she might be more helpful with a few hypotheses.

For one, it is dubious if life in western Europe was even more settled before the 16th century, and it is, therefore, likely that forces for convention and order were likely to gain the upper hand. Again, Philippe Aries' *Centuries of Childhood* would seem to supply a fitting explanation. Women were more influential in determining the moral life of their families by the 16th century and more attentive to the sexual purity of their male offspring. For these mothers prostitution was anathema. Again, the author touches on the fascinating topic that civil authorities in the 14th and 15th centuries may have attempted to cordon off prostitution districts because so many women were attracted to the ancient profession.

This is a line of inquiry which deserves further consideration and scholarship because it might be very revealing about pre-Victorian women. By the way, it would also be helpful to the author's general thesis if we learned first how badly prostitution fared in the 16th and 17th centuries, not merely rhetorically which is conceded, but actually. Lawrence Stone surely sees a flourishing institution in England in the 17th century.

Jim McGovern, Ph.D.
Pensacola

Dr. McGovern is Professor of History at University of West Florida, Pensacola.

Cervical Adenocarcinoma: A Colposcopic Atlas

by Minoru Ueki, M.D., 73 pages, price: $30. Publisher, Isiyaku EuroAmerica, Inc., St. Louis, Tokyo, 1985.

This is a short manual totaling 73 pages, 18 are text with supporting graphs. The remaining 55 pages are primarily photographs of colposcopic findings, which are good quality, but as with most photomicrographs, it is difficult to appreciate the diagnostic properties as described. Dr. Ueki's text is presented in a succinct and clear format which makes for easy reading. This manual represents 15 years of intensive comparative colpomicroscopy, involving a total of 90 cases, which is understandable, since the incidence of adenocarcinoma of the cervix is approximately 10% of all cervical carcinomas.

Dr. Ueki's opening statement sets the stage for the clinical application of this manual, "however, even experienced colposcopists have difficulty in diagnosing adenocarcinoma and often miss the findings." Since adenocarcinoma of the cervix develops beneath the surface, glandular dysplasia and in situ lesions cannot be detected colposcopically. Invasive carcinoma of the cervix has an extremely poor prognosis and is generally diagnosed by Papanicolaou smear. Dr. Ueki stresses that the most diagnostic colposcopic findings are related to late lesions.

With these facts in mind, Dr. Ueki's Atlas is primarily more an exercise in colposcopically identifying different types of cervical adenocarcinoma which does not aid in altering the outcome of this disease. It is interesting that most of his photomicrographs are grossly "malignant" in appearance.

Dr. Ueki's postscript describes his manual best, "it is right to write down what you learnt (sic) from your own experience." Since this is the first work of its kind, I would characterize this manual as a reference library book for academician and expert colposcopist.

Francis L. Howington, M.D.
Fort Myers

Dr. Howington practices obstetrics and gynecology in Fort Myers and is co-editor of the Lee County Medical Society Bulletin.

Facial Reconstruction With Local and Regional Flaps

by Ferdinand F. Becker, M.D., F.A.C.S., 176 pages, price: $37.00. Thieme-Stratton, Inc., New York.

The author has successfully presented a description of regional and local skin flaps utilized in reconstructive surgery of the facial structures. He has made no attempt to cover the entire field of reconstruction, purposely not including full and split thickness skin grafts, and myocutaneous flaps.

A selection of practical and frequently used flaps is presented for the more commonly encountered problems of the face and facial structures. These flaps have stood the "test of time," and when utilized provide rapid reconstruction of defects without delay grafting.

Each anatomic area of the face is treated separately such as eyelids, nose, and lips. Individual flaps for reconstructing these areas are well presented with excellent photographic representation including the preoperative problem, intraoperative photographs, and results.

The last chapter on complications is frank, straightforward, with excellent criticisms and in-depth constructive comments.

Any facial plastic surgeon will find this publication a comprehensive review of a large variety of very useful, soundly based, reconstructive options.

Troy H. Hutchinson II, M.D.
Lakeland

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3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

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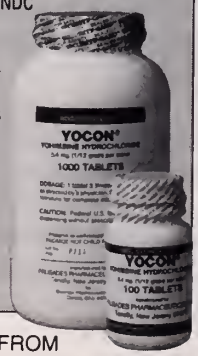

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Stress in the Medical Family

When I was asked to write an article on stress, I thought it would be easy because everyone knows what we mean when we say "stress". But do we? According to Webster's New World Dictionary, stress is the "strain or straining force exerted upon a body that tends to strain or deform its shape or the opposing reaction or cohesiveness of a body resisting such force." Applying this definition to the medical profession, we become aware of the many forces being exerted upon physicians, their spouses, families and society in general. Those that quickly come to mind are: economics of medicine, expectations of the public that doctors can do all things and are expected to do all things, changes in medical delivery systems, constantly increasing adversarial relationship between doctors and patients, malignant malpractice situation; not to mention family issues such as cost of education, explosion of activities we are all expected to participate in—parents as well as children—and the resultant hurly-burly of getting from here to there with too many things to do and too little time to do it. These are only a few of the forces exerted upon our lives, deforming our shape as we once knew it and we would want to reestablish.

The second part of the definition of stress is "the opposing reaction or cohesiveness of a body resisting such force." It is this aspect of the definition which I wish to focus on in this article, i.e., the opposing reaction or cohesiveness of the medical family and its efforts to resist those forces and maintain its stability.

It would be nice if we could stop the world and get off, then calmly sit down as a family and discuss "What are we going to do about all this?" Unfortunately that is idealistic and unrealistic. Most of us are trying to fix the situation while going full speed ahead, and attempts are often misguided and ultimately detrimental. Those coming forth as symptoms of the stresses to which we are reacting and resisting are: doctors are working longer hours, they are unable to leave their work at the office, they are getting less satisfaction out of work, they are constantly worried about dissatisfied patients and the potential for lawsuits. Many are making career choices far different than they had anticipated. Others are simply retiring at an earlier age than they had planned.

Spouses are attempting to adjust by taking more responsibility for the home and children. Families are less cohesive because these burdens shift down the line even to the youngest child who sees less and less of the parents. Some physicians and spouses pay the price with emotional and physical illnesses. Some resort to self-medication for mental and physical distresses, leading to drug abuse. Others increase their consumption of alcoholic beverages attempting to alleviate the stress they feel. Children become more susceptible to peer pressure which often encourages the search for solutions in unacceptable ways including sexual acting out, drinking and drug use. Physicians and their families may feel isolated from medical colleagues as well as the nonmedical community. There is increased irritability, depression, and sometimes major marital discord, including divorce. All this sometimes results in an attempt to "buy happiness" with increased purchasing of homes, clothes, cars—misguided attempts to gain equanimity which, in turn, creates more hostility and alienation from the public as well as increased stress on the medical family.

So far all I have done is identify some of the stresses and our attempts as medical families to adapt. There has been no indication whether any are "good" or "bad." I am saying that these are the signs of our reacting to increased stresses. I am sure many of you could enumerate ways to respond which I have not mentioned.

Next month I will share my thoughts on some constructive ways that may be effective in adapting to these stresses.

Mrs. James A. (Mary) Alford
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8th Review of Practical Dermatology for the Primary Care Physician, May 5-8, The Grosvenor, Lake Buena Vista. Contact: Elaine Halverson (904) 622-6315.

Advanced Cardiac Life Support Provider Course, May 7-8, Tampa, USF College of Med. Contact: J. Paul Michlin, M.D. (813) 251-6911.

Current Concepts in Wound Healing and Photography for Cutaneous Surgery, May 10, Boca Comm. Hosp., Boca Raton. Contact: Larry Garland, M.D. (305) 547-4477.

Pediatric for the Practitioner: Update on Genetics, May 13, Sheraton Tampa East, Tampa. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Risk Management Seminar, May 14, Holiday Inn Airport, Jacksonville. Contact: M. P. Demos, M.D., (800) 431-3878.

ECG — STAT! May 18-22, Belleview Biltmore, Clearwater. Contact: Henry Marriott, M.D. (813) 894-0790.

Magnetic Resonance Imaging: A Technologists New World, May 19-21, Palace Hotel, Lake Buena Vista. Contact: Martin Silbiger, M.D. (813) 974-2538.

Psychophysiologic Aspects of Hypnosis, May 20-22, Palm Beach. Contact: Linda K. Tower (305) 547-2000.

Advanced Cardiac Life Support Instructor Course, May 21-22, USF College of Med., Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

ACLS Instructor Course, May 21-22, USF Coll. of Med., Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

4th Annual Clinical Virology Symposium, May 22-25, Holiday Inn Surfside, Clearwater Beach. Contact: Steven Specter, Ph.D. (813) 974-3281.

9th Annual Child Neurology Postgraduate Course, May 23-26, Sonesta Beach Hotel, Key Biscayne. Contact: Oscar Papazian, M.D. (305) 662-8330, ext. 4822.

Magnetic Resonance Imaging, May 23-27, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

The Role of Calcium Antagonists in Cardiovascular, May 25, Sheraton Grand Hotel, Tampa. Contact: Stephen Glasser, M.D. (813) 974-2880.

Master Approach to Cardiovascular Problems, May 28-30, Contemporary Hotel, Lake Buena Vista. Contact: Robert Myerburg, M.D. (305) 549-7124.

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Meeting of the Florida Hand Society, June 3-4, The Breakers, Palm Beach. Contact: Mas Massoumi, M.D., (305) 655-9455.

Basic Trauma Life Support Provider Course, June 4-5, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D., (813) 251-6911.

8th Annual Cancer Conference, June 9-11, Longboat Key. Contact: Henry Azar, M.D., (813) 974-2745.

Breastfeeding — Science Behind Success, June 13-15, Hilton Hotel, Lake Buena Vista. Contact: Carol Kolar (219) 462-42027.

Risk Management Seminar, June 18, Hyatt Regency, Tampa. Contact: M. P. Demos, M.D. (800) 431-3878.

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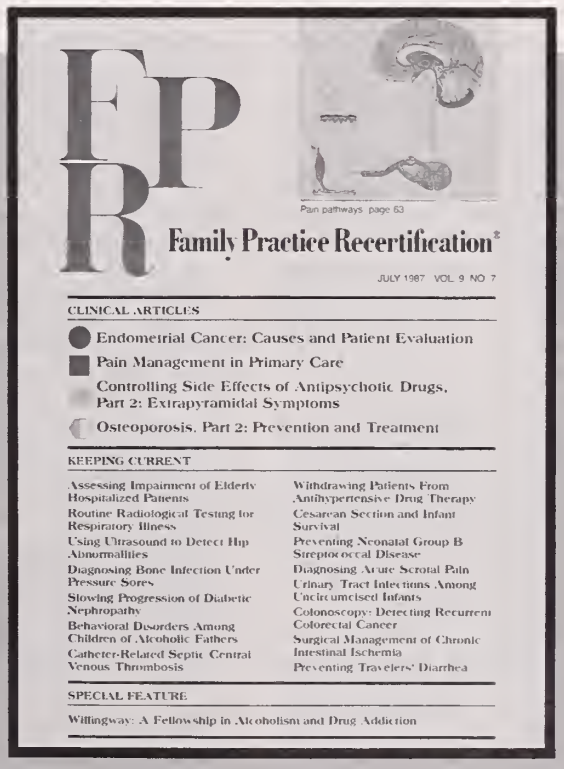
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IMMEDIATE OPENING BC/BE clinical adult Neurologist with experience in EEG, EMG & VEP. To join established busy Neurological Group - East Coast of Florida. Competitive Base Salary, incentive benefits with early partnership available. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1442, Jacksonville, FL 32203.

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INSTRUCTOR IN PATHOLOGY a non-tenure track full-time position in the Department of Pathology, Division of Surgical Pathology, University of Florida. Position requires board certification by American Board of Pathology, minimum of one year post-residency fellowship in surgical pathology and cytopathology with emphasis in gynecological pathology and cytopathology, collaborative and individual research and teaching of cytology to residents and medical students. Recruiting deadline is May 31, 1988 with a start date of July 1, 1988. Interested candidates should contact Edward J. Wilkinson, M.D., Pathology, Box J-275, JHMHC, University of Florida, Gainesville, Florida 32610. AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER.

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EMERGENCY PHYSICIAN WANTED for Humanan Hospital SunBay, St. Petersburg Florida. Must have ACLS ATLS and current Florida license. Send CV to: Emergency Medical Associates of St. Petersburg, c/o S. MacLeod MD FACEP, 500 Brightwaters Blvd. NE, St. Petersburg, Florida 33704. Or Call 813-823-5004, 813-823-1122 ext. 434.

ORTHOPAEDIC SURGEON — Position available in an established practice in Ocala, Florida for a BE/BC Orthopaedist. Possibility of an association or partnership depending on interest and suitability. (904) 629-7011.

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OB/GYN — The largest multi specialty medical clinic in St. Petersburg is seeking qualified candidates to join a 3 physician department. Must be BE/BC. Guaranteed minimum salary plus excellent benefits. Send C.V. to: Michael R. Rohr, Administrator, Suncoast Medical Clinic, 700 6th Street South, St. Petersburg, FL 33701.

NEUROLOGIST for association with established neurology practice serving Tampa Bay Area. Outstanding compensation/benefits. Partnership opportunity. Mail CV ;to P. O. Box 272954, Tampa, FL 33688.

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OPPORTUNITIES FOR FAMILY Practice/General Internist, Board Certified or Board Eligible, to join an expanding Family Practice group in one of the fastest growing counties in Florida. Send resumes to: Mr. Martin E. Dolence Jr., CPA, 6314 Corporate Court, Suite C, Fort Myers, FL 33919 or call (813) 489-2227.

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GENERAL THORACIC & VASCULAR SURGEON as associate or share office space in Orlando area. Florida license and Thoracic Boards. C.V., photo and personal information with references first letter please. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1366, Jacksonville, FL 32203.

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FLORIDA LICENSED M.D. with broad experience in clinical practice. Administration and quality assurance seeks employment opportunity in the Stuart, Vero Beach, Melbourne area. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1466, Jacksonville, FL 32203.

PEDIATRICIAN SEEKS Opportunity to work fulltime/parttime in group practice clinics or public health. Completing pediatric residency in July 1988. Call/write: (305) 431-0921; A. Brillante, M.D., 1960 N.W. 107th Ave., Pembroke Pines, FL 33026.

44 YEAR OLD B/E INTERNIST-NEPHROLOGIST, Florida license, residing in Florida, is interested in either purchasing an established family or medical practice, or associating with another physician. Full-time position also considered. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1457, Jacksonville, FL 32203.

WANTED: INTERNAL MEDICINE in Ormond Beach/Daytona Beach area. 20 years experienced Board Certified Internist with Florida License looking for Private Practice opportunity (partnership or group). Also has SUBSPECIALTY experience. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1459, Jacksonville, FL 32203.

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Feature Editor — **Dale C. Havre, M.D.**

Let's Leave Business to Businessmen, and Medicine to Physicians

Something that always rankled me over the years was the frequently expressed opinion that doctors are "lousy businessmen." Invariably that annoying generalization came from individuals outside the medical profession who seemed eager to get their hands into the doctors' till. They always offered their services with the attitude that what is good for business in general is good for medicine, too. That may be true within limits, but experience has shown there are very definite limits. I'll bet there are more than a few hotshot MBAs who wish they had never seen the inside of a HMO.

No one will deny that there are some imprudent money managers among physicians, but that does not mean that all doctors are financial fools. Quite the contrary, my impression has been that most physicians handle their financial matters quite skillfully. You have to look long and hard to find a physician's practice listed under the bankruptcy section of the newspaper. On the other hand, it's amazing how frequently other so-called small businesses, with genuine businessmen at the helm, go belly-up from Chapter Elevenitis.

I can remember encountering that lousy-businessman theme as far back as my days in medical school. At times the denigrating remarks about our lack of business acumen could be heard over the thunder of Admiral Perry's cannons on Lake Erie. That's how long the entrepreneurs have been trying to get their Gucci-covered feet into the door of medicine. And that, unfortunately, is what they have finally done. The aggressive merchants circled the house of medicine and whooped and hollered until some misguided souls within our own ranks finally weakened and let them into the very place where we live. Their promises of fiscal fecundity were more than some of us could resist.

And just what is it that these masters of the market have done for us as individuals or as a profession? Well, first they convinced us that we were incapable of running either our hospitals or our offices. Consequently, we were obliged to hire business managers, public relations office's and personnel directors to do all the tasks we used to do ourselves — only now it costs us a hundred times more to do it. It seems as if we are also in need of media consultants, ad writers, booking agents, development planners and Harvard MBAs or we are doomed to obscurity and failure.

Furthermore, if our waiting rooms aren't filled with banks of TV screens promoting the latest "laser beam" procedures or other miracles of the modern high tech medical-industrial complex, then we are made to feel as if we are shameless anchronisms. We are urged to hang up our unamplified stethoscopes on our mercury-filled sphygmomanometers and sign up immediately for the first available course in profit-taking through advanced technology.

Not that I am against improved technology in medicine, mind you. Who would ever want to reliquish the CAT or NMR machines and go back to pumping air into brains? Not I. But I do think I could live without a macromega computer system that can tell me when I've seen my zillionth case of crusty eyelashes and how profitable that diagnosis has been for me during odd numbered years. Some things are important to patients and some are not — even if the data look great on paper.

Ever since the purely profit-driven types have been allowed to roam freely in the house of medicine, it has become a time — consuming job sorting out what patients really need and what the entrepreneurs claim they must have. Doctors have done a great job of doctoring over the centuries, and I think we should reaffirm loudly that business is business and medicine is a profession. They should not be mixed in equal proportions.

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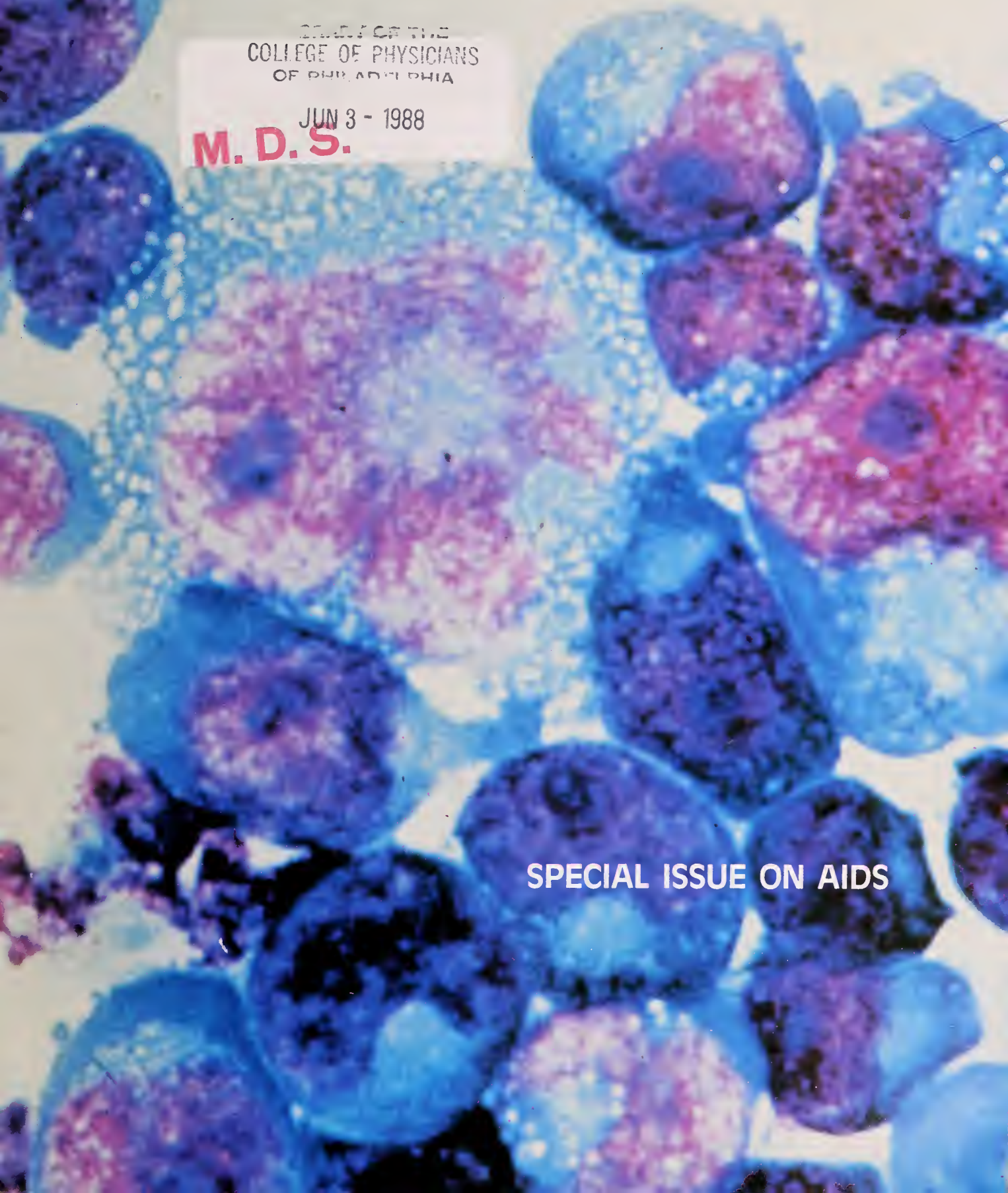
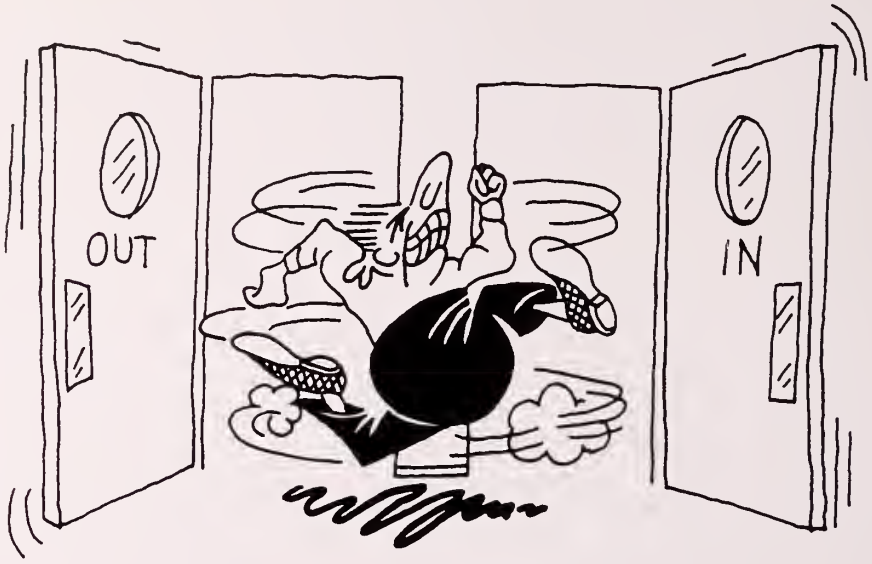


SPECIAL ISSUE ON AIDS



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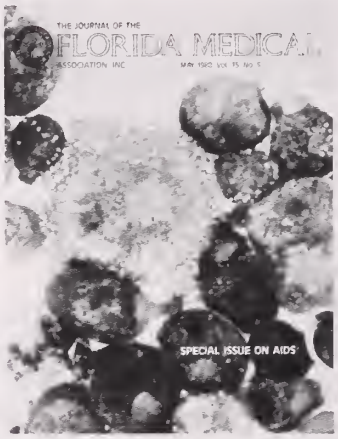

COVER

HIV infected T-cells cluster in a sinister embrace giving rise to the AIDS virus, the special focus of this month's *Journal*. Probably not since the bubonic plague that ravaged Europe in the Middle Ages has a virus caused such universal concern and fear. To this end, this issue of *The Journal* is devoted to expanding our knowledge of this dreaded disease. (Photo courtesy of Dr. Tom Folks, National Institutes of Health).

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By now, all our members should have received a bill for the constitutional initiative assessment. This bill may come as a surprise to some members. During a recent trip to Escambia County, I was asked several questions regarding the assessment such as who authorized it and why it was necessary.

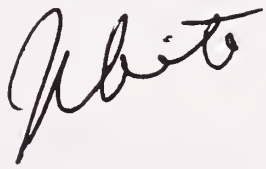
You are all aware that each county medical society or association elects delegates to the FMA House of Delegates. During the Annual Meeting in September 1987, the House of Delegates voted the $500 assessment of each member contingent upon the Florida Supreme Court ruling that the amendment as drafted addressed only one subject and that the title and explanation were clear. As you know, that has occurred; so now, as directed by the House of Delegates, we have called the assessment. All of those physicians who have voluntarily paid the full $500 will not be further assessed. Those who have paid part of the total will be billed for the balance.

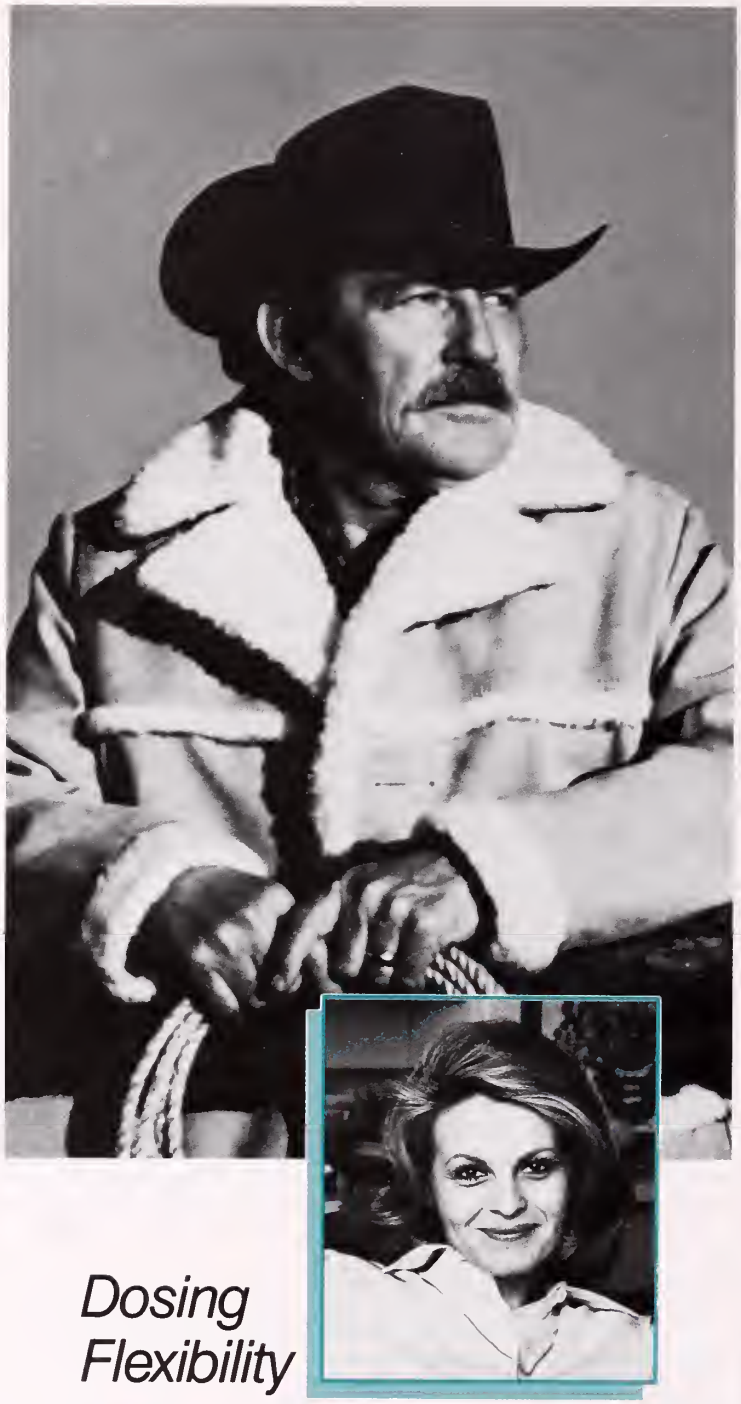
We have cleared one major hurdle in having the Supreme Court rule favorably. We are nearly over the second hurdle of collecting the necessary valid signatures to get the amendment on the ballot. In order to succeed with the next phase, we must have the necessary funding.

Our amendment campaign will be very expensive and will easily require several million dollars. I urge you to send your check today. I know that many of our members are skeptical and are still bitter over the failure to get on the ballot in 1984. This is past history and we must not dwell on it, lest our current efforts be diluted.

The public clearly understands our plight and will support our efforts if we will but ask. Please continue to ask your patients, friends and neighbors to sign the petitions.

My thanks for your continued help and support.





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EDITORIALS

The Wrong Prescription

Universal health care, or health care for all as it is being heralded by its promoters, looms as one of the major issues in the coming presidential elections. Democratic hopeful Michael Dukakis recently signed legislation making Massachussetts the first state in the nation to embrace mandatory health insurance and vowed further to campaign for the same on a national basis. Although George Bush has not made known his plans, it is expected he will oppose mandatory health insurance.

Universal health insurance actually is an old concept being repackaged under new labels. The closest version to it is the National Health Service of Great Britain, or socialized medicine. Congress has made many attempts in the past to legislate the same to Americans but failed every time because the public did not like it. The impetus to revive it at this time comes mainly from the escalating cost of medical care, making health insurance unaffordable to many American families. A recent poll showed that most Americans want to continue to enjoy liberal medical care benefits, but only close to 25% want to pay for the cost of such benefits.

In theory, legislating health care for all Americans sounds like a rational manifestation of the widespread belief that medical care is an inalienable right, much like the pursuit of life, liberty, and happiness. Unfortunately, it is not quite that simple. Translating the concept into practice is something else.

The first question asked by a lot of people when Governor Dukakis signed the Massachussets health care law was this: Who will pay for it? Americans should be asking Dukakis and his cohorts the same question as they stump across the country advocating mandatory national health insurance. Politicans trying to bamboozle voters are notorious for underplaying the expenses involved in such grandiose plans. Medicare is a classic example. Congress ignored the warnings of physicians about the potential astronomical costs of the program and proceeded to pass a law that created one of the biggest boondoggles in legislative history. Only a few years after its inception, the costs of the Medicare program ballooned beyond the wildest expectations of its sponsors, leading to recurring fiscal problems and even talks of possible bankruptcy. The offshoot of all these problems is the torrent of cost-containment measures, familiar to all physicians, enacted by Congress over the last several years, with increased out-of-pocket expenses for Medicare enrollees, reduced benefits, and reduced reimbursements for physicians. And what about Medicaid? Although the federal government contributes part of the largesse, state governments have been extremely docile when it comes to allocating dollars for the program. Medicaid, as a result, has become the prototype of how not to run a nationally subsidized health care program. The scenario is not going to be much different with the proposed mandatory health care plan.

Apart from being expensive, universal health insurance is certain to dismantle the current structure of the American health system. The HCFA, through the Medicare program, has already partially eroded the foundation of that system. The proposed plan by Dukakis is certain to complete that erosion. Consider what is likely to happen: There will be a massive bureaucracy with the power to make regulations, to fix fees, and to tell physicians how they should practice medicine. Physicians will be working like indentured servants. Patients will become anonymous faces, and quality of care will become a thing of the past. Sounds familiar?

The National Health Service of Great Britain ought to be an example of what could happen here. Although it is true that medical care is free to all Britons, patients and physicians alike are extremely disillusioned with the system. Hospitals are getting decrepit and many are underequipped, waiting periods for elective procedures are getting longer every year, certain medical services are being rationed, and the best British physicians are migrating elsewhere. Meanwhile, the government of Prime Minister Margaret Thatcher is pressured to lay aside more money to salvage the system.

Can it happen here? Certainly. Universal health insurance is a disaster waiting to happen. It is the wrong prescription for Americans, and they ought to reject it overwhelmingly come November.

R.G. Lacsamana, M.D.
Editor

What Are the Obstacles?

The FMA and physicians in Florida are presently engaged in a campaign to put a $100,000 cap constitutional amendment on the ballot for November 1988. All physicians have been advised and have received numerous communications from the FMA office in Jacksonville outlining the proposal. It has been generally agreed that this is the only thing that is going to drastically reduce the rapidly escalating malpractice insurance premiums for physicians and it will not be accomplished unless physicians accomplish it. The state Legislature has shown no inclination for passing a law imposing this cap. The optimism that this will reduce malpractice insurance premiums is based on the experience in California where a $250,000 cap was imposed on noneconomic damages. This was upheld by the Supreme Court and it has drastically reduced the malpractice premiums for all specialties in that state. The special session of the Florida Legislature in January 1988 did impose a cap of $250,000/$350,000 on noneconomic damages but, of course, this has to withstand judicial review. The past record of the Florida Supreme Court in striking down such provisions indicates that this may be declared invalid. Accordingly, the drive to introduce the constitutional amendment is now going forward.

There are at least three major obstacles which have to be overcome in order to make this amendment a part of the Florida constitution. The first is getting the required number of signatures for the proposed amendment to be put on the ballot — over 340,000 valid Florida voters. At present we have approximately 230,000. There is a drive going on that hopefully will gather more signatures. This effort probably will not obtain the required number; so, therefore, the first obstacle has not been overcome.

This is an obstacle that could have been overcome easily by Florida doctors, but not all participated and many did not even get one signature on a petition. To make matters worse, some physicians are not registered voters; they cannot sign a petition themselves. This was drastically emphasized to me when out of curiosity I checked voter registration of physicians in my area who had indicated they were solidly behind the petition drive and would work to see that it was successful. Some were not registered. If a physician will not take the time to register, then I suppose he will not take the time to get signatures either.

The required number of petitions probably will be achieved; the FMA will hire a professional team to get the job done. It will probably cost on the average $3 to $4 per petition and, therefore, will reduce the campaign funds that will have to be set aside once the petitions are gathered.

The second obstacle will be to collect the money required for a successful public relations campaign directed to the Florida voters to get them to pass the constitutional amendment. The FMA has sent out a notice that it is assessing each member $500. It is generally thought that a campaign will cost anywhere from $4 to $8 million. It can be expected that the trial attorneys of Florida will match dollar for dollar and try to surpass that in what will be a vicious fight. But there can be no campaign if the money is not raised. The FMA has no authority to make a person pay $500. The only thing the FMA can do is to drop that person from the rolls of its organization and from the county medical society to which the person belongs. To many people this may not appear harsh and they may elect not to pay the $500. The only incentive for a person to pay $500 is his/her own conscience and the knowledge that this is necessary in order to successfully educate and explain to the voters of Florida the necessity for the constitutional amendment. There are many people who think that there will be a substantial number of doctors who will opt not to pay the $500. There are others who believe that the majority will recognize the necessity for this and the fact that it is the individual doctor's responsibility to be a part of the cost of any effort which will benefit him/her as well as the whole of medicine.

The last obstacle is to educate the voters in Florida. This will be an intense, emotional and spirited campaign. The trial attorneys have already gone on record stating their opposition and they will be gearing up their campaign. The campaign on both sides will involve radio, newspapers and television and may get down to a low level. The physicians in the state and the FMA must be prepared to go the distance to match the trial attorneys and others who will be against the constitutional amendment and be prepared to logically, consistently and vigorously defend their points of view. There is no doubt in my mind the FMA has the representatives to do that and the individual doctors have the knowledge and potential to be a source of information for millions of patients who visit them every day.

There was another obstacle but it has been overcome and eliminated. The Florida Supreme Court

reviewed the proposed constitutional amendment and by unanimous vote ruled that it meets all requirements to be on the ballot in November.

As I have explained, the three major obstacles will be overcome. I have no doubt that even though we may not reach the required number of petitions by efforts of physicians that we will have the required number by August to enable the constitutional amendment to be placed on the ballot. I also have no doubt that most physicians will contribute their $500 as they believe this is their fight. There will be some who will not, who will let others carry the burden and they will reap the benefit. To those I can only say that they must live with their conscience. If they feel that this is the proper and right thing to do, then I suppose it is up to them to make that decision. It is, however, not the right and proper thing to do from any reasonable, ethical point of view.

I feel that the last obstacle, convincing the people of Florida that this is the right thing to do, will be the most difficult to overcome and there the battle will be won or lost. It is hoped that all physicians will participate in all phases and overcome these obstacles. As we go toward the November ballot, we must continue to be apostles of the necessity of passing a constitutional amendment placing a $100,000 cap on noneconomic damages.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach

Where Have All the Nurses Gone?

Four telltale signs at a local hospital where I practice told me last year that the nursing shortage was on again: the ER was unusually crowded with patients waiting to be admitted; part of the Critical Care Unit was shut down; the nursing recruitment office opened its doors once again, and nurses were bitching more than usual. What many people thought was a temporary aberration when nurses were nowhere to be found a few years ago turned out to be a critical problem this time. Stories in the national press and on television told of many large-city hospitals closing down their beds, of overworked nurses stretching their hours and their patience to the limits, and of patients not getting the care that they needed. It was a situation waiting to explode.

But where did the nurses go all of a sudden? Although we are continually being assured that there are enough nurses around, more and more of them are deciding to retire early, transfer to other professions, or go into other fields of nursing away from bedside care. New entrants to nursing schools are also fewer despite some encouraging numbers a few years ago.

Nurses offer the best explanation of why fewer people go into nursing and why many of those already there are trying to get out: poor working conditions, meager pay, an abundance of stresses, and a general lack of appreciation for what they do. They all sound familiar, yet it appears we have paid but lip service and have done little to address what nurses have been telling us for sometime.

Advances in medical care and increasing demands on the health care system will require an increasing supply of nurses today and in the future. We cannot forever depend on temporary imports of foreign nurses to bail us out of our periodic shortages or to expect already overworked nurses to put in more sacrifices. The problems are known, the solutions should be there, and all of us involved in taking care of patients should work together to ensure that nurses get their just rewards.

As the National Nursing Week come to a close this month, I was struck by a bumper sticker: DO A GOOD DEED TODAY; LOVE A NURSE PRN. The problem is we may not have enough of them to hug everyday.

R. G. Lacsamana, M.D.
Editor

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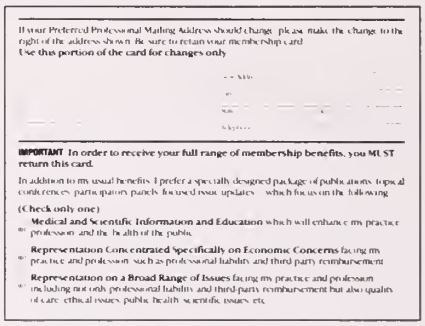

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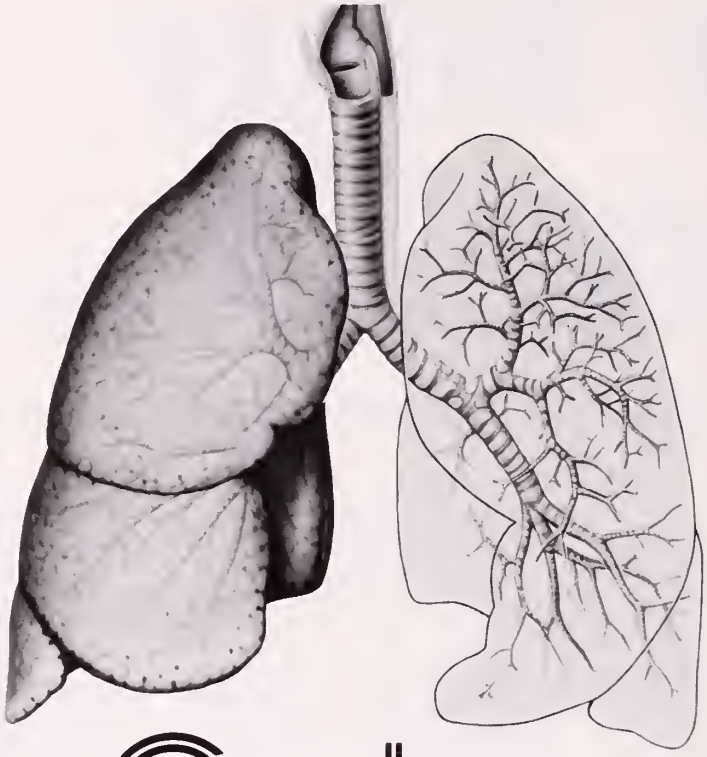

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CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
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LETTERS & VIEWPOINTS

Coercion and Socialized Medicine

As a "young" physician (one who enjoys membership in the "Young Physicians Section" of the AMA and FMA) I have particular concerns as to my future ability to provide high-quality medical care to my patients. It seems to me that the government federally and now statewide has committed itself to a plan of coercion that can lead only to socialized medicine.

As a nonparticipating physician, I complained bitterly to Medicare that I felt it was unfair for them to print messages on their EOMBs unrelated to medical care. I am referring to their ad justified by Social Security Act Section 1842(1) which encourages patients to see participating physicians. In fact, patients are coerced into using participating physicians. Otherwise they may receive no reimbursement from an insurance plan into which they have already made payments, at the arbitrary discretion of that plan (to wit: Medicare).

On 3/21/88, I did an examination on a patient at my office. The diagnoses were blepharitis and incidental benign eyelid tumor. The blepharitis was treated. The patient was denied reimbursement from Medicare on the office visit. The EOMB message reads that her treatment was not medically reasonable or necessary.

On 2/3/88, I performed reconstructive surgery to restore a patient's sight. The patient received the same above mentioned EOMB, stating that my treatment was unnecessary and not medically indicated. Consequently, reimbursement was denied. However, this inflammatory EOMB basically implies that I have committed medical malpractice.

Denying payment for nonparticipating claims whether they be office visits or outpatient surgery is objectionable. Citizens enjoying a free, capitalistic society have contributed to the Medicare system and deserve the benefits of reimbursement. The government is coercing patients and physicians into socialized medicine by taking patients' money and not reimbursing it to them accordingly.

In Massachusetts, home of Mr. Dukakis, physicians must sacrifice their licenses to practice medicine if they do not "participate" in the system. This legislation came about because 95% of Massachusetts' physicians were participators prior to this coercive legislation. Florida legislation has been introduced that would cause physicians to lose their licenses if they were in violation of Medicare Actual Allowable Charges.

As a young physician, I urge all Florida physicians to think twice before they accept assignment. I urge you to resist efforts of coercion because it removes medical care from your healing hands and paves the road toward further governmental intervention and socialized medicine.

Linda J. Kaplan, M.D.
Hallandale

Treating the Terminally Ill Patient

Recent advances in medical technology have made the time of death a matter of deliberate decision. Modern medical therapies have enabled physicians to not only prolong life but also to extend the process of dying. As patients and their families realize that they are under no obligation to accept a given treatment simply because it is available, more are choosing not to prolong a certain death.

Once it is agreed that certain patients will not receive life-prolonging treatment, then the difficult process of decision begins. . which patient, what kind of treatments, who decides, when and on what basis. Reaching answers to these questions requires great caution. The moral principles which underline such decisions need to be clarified to render the whole issue of withholding and withdrawing life-sustaining therapy morally sound.

Decision Making Guidelines

The right to decide about one's own health care is the prerogative of each individual. It is a constitutionally protected right exercised by a competent well-informed person. The basic ethical principle is that of autonomy. The model of informed consent and refusal of medical treatment is predicated on the concept of a free moral agent choosing among available options. The presumption is that individuals have value preferences based on religious, moral and philosophical beliefs and that they should be allowed the personal autonomy to decide their own fate in accordance with these beliefs. Although the presumption in favor of treatment is an imperative to which physicians are committed, they must recognize that the right of a terminally ill patient to forego treatment

is protected by the individual's right to privacy and self-determination.

Only when a patient is declared incompetent can others exercise their judgments on his behalf. The courts are the legally required place for adjudicating incompetency. However, competency decisions are customarily made extra-judicially and are often not reviewed by the court, except when required by state law or when disagreements between participants cannot be resolved. The determination of incompetence can be made by an attending physician when there is a consensus on the part of the patient's family and friends and other health care professionals.

When a patient is declared incompetent, the physician must rely on a Living Will or an advance directive to determine what the patient desires. The incompetent patient's right to self-determination may also be extended to an appropriate surrogate, generally a family member or a close friend, designated in advance by the patient to speak on his behalf.

The physician has an important role in the decision making process. She/he must provide information about diagnosis, prognosis and treatment options. Physicians should recognize that, in some circumstance, it may be best to do less rather than more for severely ill patients. The tendency to equate death with failure must be acknowledged and reassessed in the light of the patient's medical condition.

Foregoing Life-Sustaining Therapy: Easing the Social Burden?

The issue of foregoing treatment for hopelessly ill patients is complex and controversial. On the other hand, there are good reasons to believe that unquestioned administration of extreme and expensive medical technology is not always in the patient's best interest; on the other hand, there is a troubling potential for abuse.

Daniel Callahan of the Hastings Center in New York argues that we have now focused on this issue because it provides us with a way to eliminate the "biologically tenacious", i.e., those who simply will not die, but who are so severely disabled that they can easily be discriminated against by the able bodies who dominate society. Perhaps, because of the present cost-consciousness in medicine, the provision of long-term support for such patients may seem to be a social burden more than a benefit.

Whatever the rationale, the reasonable argument seems to be that with some dying patients we ought to be allowed to stop extreme and expensive treatment including artificial nutrition and hydration. However, such a possibility should not provide us with a way to embark on a course of sacrificing living but incompetent and disabled patients for the admitted social good of containing health care expenditures. Such actions will violate the morality of our society and should be actively resisted.

Health care institutions have an obligation to establish written policies about foregoing life-support measures including artificial hydration and nutrition. Such policies can resolve some of the major dilemmas when deciding to forego life-sustaining treatment for the hopelessly ill. They cannot however, address all the issues involved in caring for these patients. One must be vigilant not to use policies as "rubber stamps" to support decisions which, although apparently ethical, are in fact abusive, discriminatory and, therefore, unacceptable. In an era of scarce medical resources the tendency to elevate a political and societal expediency to the level of a moral principle is great. Such tendency must be recognized and categorically rejected.

Robert A. Brodner, M.D.
West Palm Beach

Dr. Brodner is a board certified neurosurgeon in private practice in West Palm Beach.

Reactive Arthritis Following a Sting by a Portuguese Man-of-War

The Portuguese man-of-war is a common pest on the beaches of Florida. Unfortunately, it is not harmless. In the spring of this year, 1988, the local newspapers carried a story of a woman who died following a sting by a man-of-war while swimming in Boynton Beach.

The man-of-war is a siphonophore called *Physalia* and related to jellyfish. It is not an individual but a colony of animals joined to form a community body. Different parts perform various functions, swimming, feeding, stinging, or reproduction, etc. Its most prominent feature is the large, blue and pink, gas-filled, float that supports the colony on the surface. On top of the float is a sail that stays 45° to the wind. Beneath the float there are elastic, stinging tentacles, looking like blue threads that trail for many feet, sometimes 50 feet, under the surface. On contact with the threads or the body of the man-of-war there is severe pain because of the intense, paralyzing poison. The pain following contact with the poison of the stinging cells, called nematocysts, lasts at least two or three hours. Then follows an allergic or histamine reaction, resulting in a painful reddened area at the point of the sting.

In November 1986, I went to the beach at Boca Raton. It was a windy day and the blue flag was flying at the lifeguard station. A blue flag means that Portuguese man-of-war are in the water. A southerly wind

drives them from the Gulf Stream on to the Florida coast. I asked the lifeguard whether there was a problem. He made light of the situation, saying there had been a few water pests sighted but not for the last few hours. Foolhardily I went into the surf; seconds later I felt the sting in my left arm on the medial aspect over the biceps area. The pain was intense and accompanied by a feeling of fainting and dizziness. My pulse was weak, and my wife, an R.N., told me I looked pale. The lifeguard had only rubbing alcohol for relief. After an hour we found a drug store that was open on Sunday and as I had a Rx blank in my wallet, I was able to get a antihistamine pill that provided relief from the intense pain, the dizziness, and I am certain the hypotension. The redness and edema over the site of the sting lasted three days but as I continued the antihistamine medication there was no pain. That was only the beginning; within a week a major problem began.

Suddenly, I developed swelling of the dorsum of both hands with severe pain in both wrists, more severe on the left side. What followed was a typical case of remitting seronegative symmetrical synovitis with pitting edema, the RSPE syndrome. This syndrome, first described in the literature by McCarty et al, describes this problem mainly in elderly males. I was 74 at the time and am a white male. Except for an elevated sedimentation time, a full range of laboratory tests were normal. Treatment consisted of wrist splints, rest of the affected joints, hot wax treatments, and nonsteroid, antiinflammatory drugs. There was improvement, but not complete until I was given a small dose, 5 mg, of cortisone daily for two weeks. After that improvement was rapid and led to complete remission a full year after the sting.

In all fairness to our patients it is important that the danger of man-of-war sting be publicized. As a public health measure, beaches should be closed if the *Physalia* have been cited. Then again, all lifeguard stations should be equipped with a supply of antihistamine drugs. Some of these drugs are sold over the counter and there is no legal reason why they cannot be dispensed in case of a sting by the man-of-war.

If there is blue flag flying on the beach or if the presence of Portuguese man-of-war is noted by the lifeguard or if any of the blue floats are seen on the beach — don't go in the water.

References

Phillips, Craig: The Captive Sea, Chilton Books, Philadelphia and New York City, 1954.

McCarty, D. J.; O'Duffy, D.; Pearson, L., and Hunter, J. B.: Remitting Seronegative Symmetrical Synovitis with Pitting Edema, JAMA 254: 2764-2767, 1985.

Sidney R. Weinberg, M.D.
Boca Raton

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

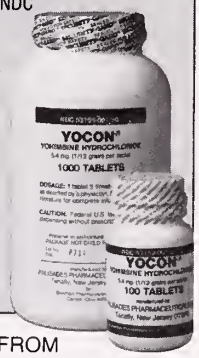
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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CARAFATE® (sucralfate) Tablets

BRIEF SUMMARY

CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate

PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other.

Issued 1/87

References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79 (suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

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0825A8

Ulcer therapy that won't yield, even to smoking

YIELD

What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine[1] and ranitidine[2] have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.[3,4] A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine[5]:

Ulcer healing rates:
(at four weeks of therapy)[5]

Sucralfate:	
All patients	79.4%
Smokers	81.6%*
Cimetidine:	
All patients	76.3%
Smokers	62.5%

*Significantly greater than cimetidine smoker group ($P < .05$).

Carafate has a unique, nonsystemic mode of action that enhances the body's own ulcer healing ability and protects the damaged mucosa from further injury.

When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

Nothing works like

CARAFATE®
sucralfate/Marion

Please see adjoining page for references and brief summary of prescribing information

0825A8

Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

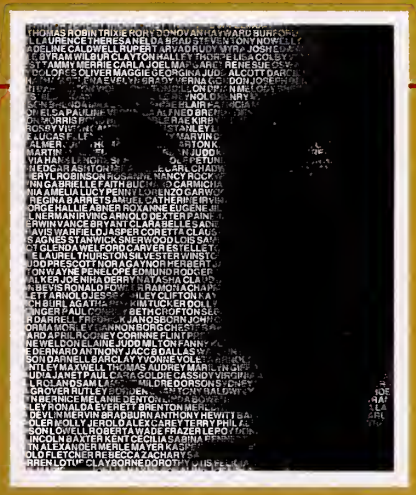
Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.

EXPECT YOUR NEXT PATIENT ON INDERAL® LA TO...

(PROPRANOLOL HCl)

LONG ACTING CAPSULES 60, 80, 120, 160 mg



Please see brief summary of prescribing information.

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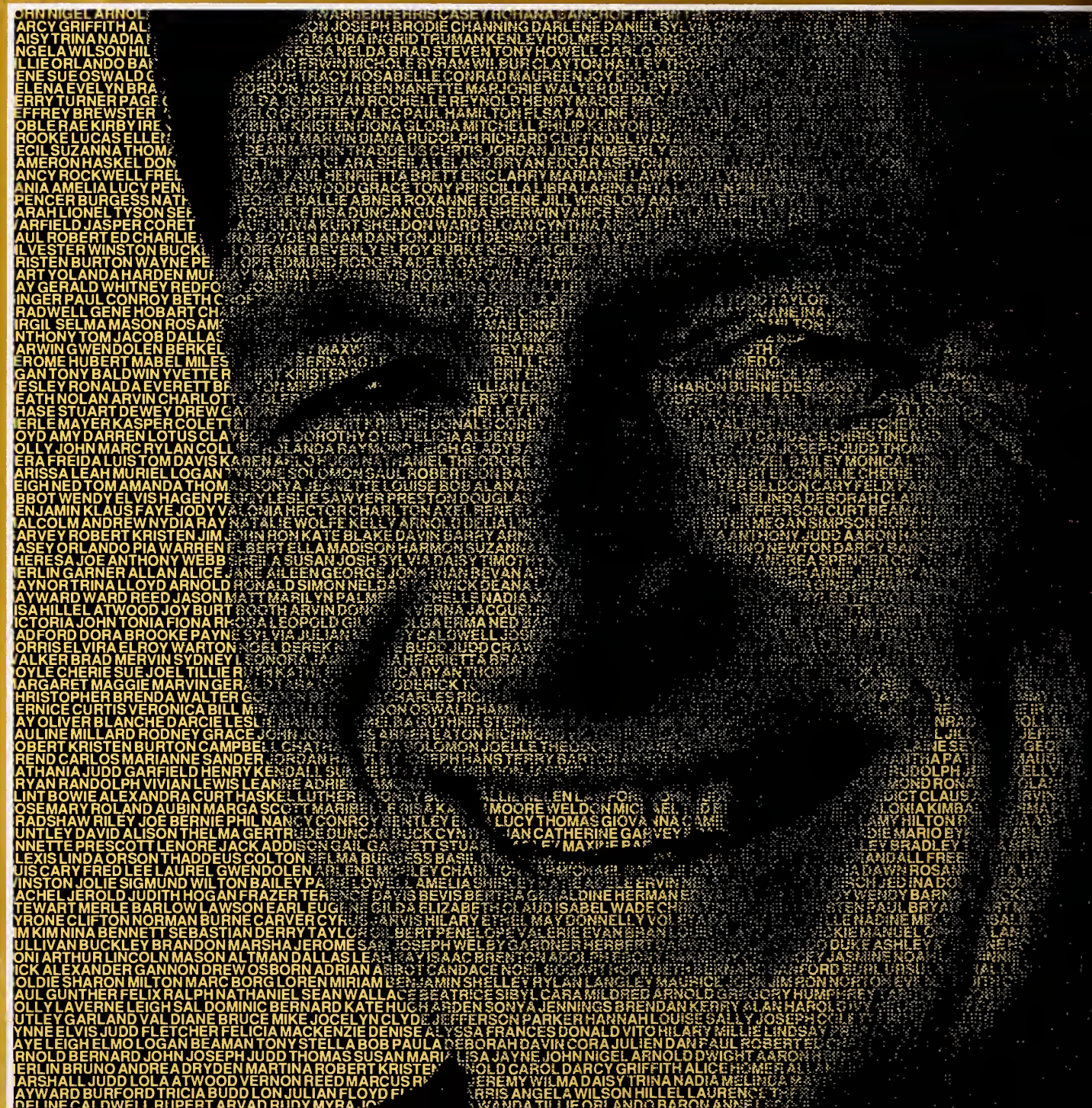

ON

...like the more than one million patients who have received INDERAL® LA.

In a recent survey, 4,120 participating physicians gave us their views[1] on INDERAL LA in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated INDERAL LA good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe INDERAL LA.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with INDERAL LA to be as good as, or better than, other beta blockers.

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES
60, 80, 120, 160 mg

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

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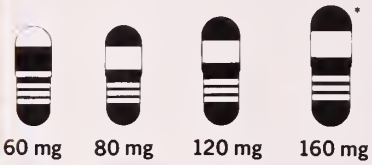

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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Freedom from pain

Just one part of pain relief therapy.

Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief—up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

- Vicodin offers the convenience of CIII prescribing.
- Dosage flexibility—1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

vicodin®

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. 5685

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med,* 141:293-300, 1981.

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A Unit of BASF K&F Corporation
Whippany, New Jersey 07981

BASF Group

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vicodin® III

hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

"Living in the city is lonely enough... with herpes it's like solitary confinement."
ZOVIRAX®
(acyclovir)
CAPSULES
Prevent genital herpes recurrences month after month with daily therapy.
(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)
Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX® (acyclovir) CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.

S6 ZOV 5

Prevent recurrences month after month*

ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73/m^2.

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709

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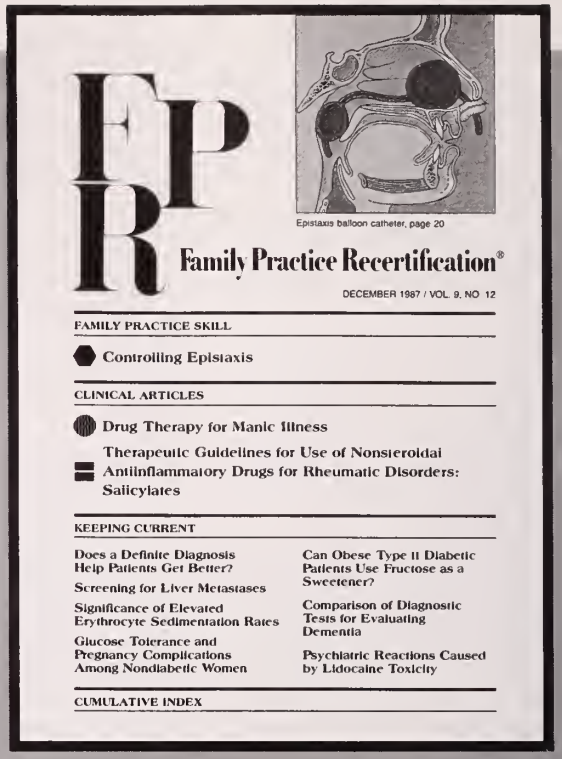
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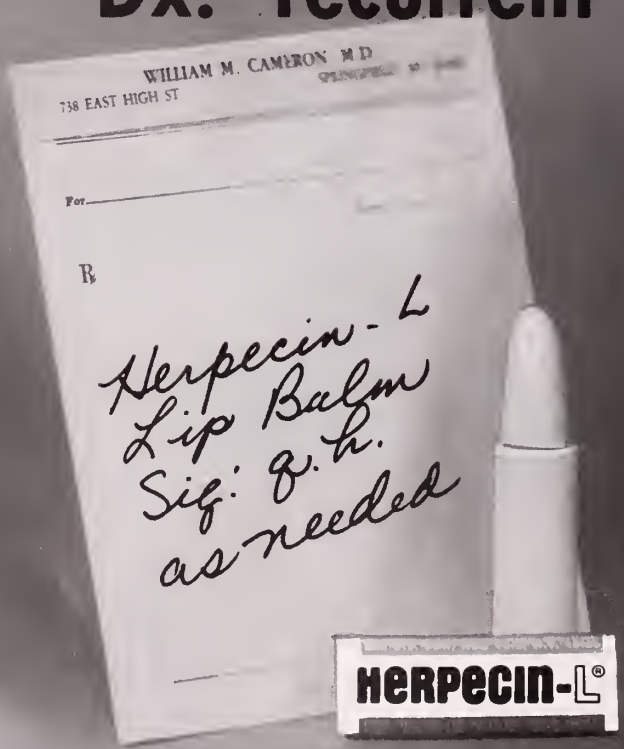

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AIDS: Initiatives and Priorities

Daniel L. Seckinger Jr., M.D.
Guest Editor

AIDS as a clinical entity was recognized seven years ago. The infective agent was isolated two years later, in 1983. The nucleotide sequence of HIV was reported shortly thereafter. In March 1985 the first serological test for the HIV antibody was introduced. The benefits of antiviral adjunctive therapy were noted in early 1986. A vaccine is eagerly awaited. With the hepatitis B model 19 years elapsed between isolation of the virus and clinical introduction of the vaccine.

Although AIDS is a preventable disease, an increased incidence is predicted over the next several years. Education directed primarily to behavior modification within those subgroups most vulnerable to HIV infection remains the primary initiative of our national prevention strategy.

Cost are enormous. Direct health care this year will approach $500 million. Unless initiatives such as hospice care impact greatly, we could be faced with AIDS health care costs of $25 billion a year by the end of 1991. The psychosocial impact of AIDS on patients, their families and coworkers further taxes this health delivery system and cannot be measured in monetary terms alone.

Society faces an equal challenge and must develop the adaptability and range of response to provide for the necessary protection of human rights of individuals involved. At the same time we must structure a preventive strategy that will insure the public of its rights to remain uninfected.

The potential for discrimination is ever present. While it is desirable to maintain that spectrum of individual rights that include total confidentiality, this cannot be absolute.

In the vast majority of cases, AIDS is a sexually transmitted communicable disease. Established public health measures are necessary to deal with AIDS as with all other preventive diseases. The recently instituted partner notification program of Florida's Department of Health and Rehabilitative Services addresses this issue directly.

Articles from six members of the Florida Medical Association Committee on AIDS have been selected for publication in this issue of the Journal. Case studies on blood exposures in the hospital setting and HIV infection in Belle Glade, Florida, are included. Monographs on AIDS and drug abuse, AIDS and children, laboratory diagnosis of HIV infection and ethics in the care of AIDS patients demonstrate the wide spectrum of interests among Committee members. This diverse professional background enables the Committee to serve as a resource to private and public sector organizations, among them the Departments of Correction, Education and Health and Rehabilitative Services.

The Committee has provided input to the Florida legislature regarding omnibus bills on AIDS, currently under consideration in both Houses. Senator William Myers and Representative Lois Frankel have made a major commitment to develop comprehensive AIDS bills. With reconciliation and the necessary modifications, it seems likely that Florida will have informed and comprehensive AIDS legislation which may serve as a model for others. Some future directions are becoming apparent.

Recently published initiatives of an Intragovernmental Task Force of the Department of Health and Human Services establish several priorities which deserve mention.

- Improved Education for Health Professionals in the Diagnosis, Care and Counseling of HIV Infected Individuals.
- Innovative Methods of Caring for IV Drug Abusers.
- New Approaches for Recognizing Mental Health Needs.

Minimizing Discriminations of AIDS Patients.
Funding Expanded Health Services Research.
Availability and Adequacy of Health Insurance.
Medicare and Medicaid Policies Related to Reimbursement.
Feasibility of Developing AIDS Specific Diagnostic Related Groups (DRGs).
Review of Hospice Regulations Under Medicare and Medicaid.

These initiatives may well represent AIDS priorities for the near term.

A phenomenon with the dimensions of the AIDS pandemic, enmeshed closely with both chemical addiction and human sexuality, challenges all elements of society. AIDS can be prevented. Education is the great hope. The family, school, clergy, employer and health professional must provide the leadership.

Daniel L. Seckinger, M.D.
Miami

Florida Medical Association

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Laboratory Diagnosis of HIV Infection

Daniel L. Seckinger, M.D.

AIDS as a disease entity was first reported in 1981. An estimated 1.5 million Americans now harbor the virus and the acquired immunodeficiency syndrome will ultimately develop in the majority of those infected. To date, less than 200,000 HIV positive antibody tests have been reported, leaving a million or more Americans with the virus, able to infect others, and unaware they are asymptomatic carriers. Fully 95% have no clinical manifestation of the disease. The long latent period of infection enhances communicability, enabling further spread by the asymptomatic carrier. The laboratory diagnosis of HIV infection thus assumes even greater significance. Self diagnosis is impossible. Those patients with ARC or AIDS represent the tip of the iceberg.

No laboratory test is perfect. If there were no false negatives or false positives, test sensitivity and specificity would be 100%. The profound social, psychological, economic and medial significance of a positive HIV antibody test makes it essential that analytical errors be maintained at an absolute minimum.

The Author
DANIEL L. SECKINGER, M.D.
Dr. Seckinger is Chairman of the Florida Medical Association Ad Hoc Committee on AIDS, and a member of the Governor's Task Force on AIDS and the Commissioner of Education's Task Force on AIDS. He is chief of pathology at Cedars Medical Center, Miami.

HIV antibody screening ● The initial test for HIV antibody, enzyme linked immunosorbent assay (ELISA), was developed and initially used as a screening procedure to identify blood products that contained the virus. More recently it has been utilized for clinical purposes. Test reagents are produced from cell culture derived virus and may, on occasion, contain cellular antigens which react with anticellular antibodies in some patient serum to create a false positive test. False positive antibody tests obtained on screening are more frequent among low prevalence populations. For these reasons, a precise confirmatory test was developed as a "gold standard" to verify positive values determined by the screening ELISA antibody test. Subsequent development of more accurate screening tests, more precise interpretation, better test standards and control and understanding of the ELISA/Western Blot testing sequence have greatly improved performance.

Data from the New York State Department of Health reported at the Third International Conference on AIDS indicate that 5% of a large study group of screening positives could not be confirmed by Western Blot, 35% were questionable and were classified as "indeterminant" by Western Blot and 60% of the antibody screening positives were confirmed. Much has been written regarding the "false positives". The implication is that this often translates to poor laboratory performance. The primary need is to provide a very sensitive test that includes all positives.

Over the years, physicians have become familiar with screening and confirmatory syphillis testing. The testing sequence takes into account biologic false positives and excludes them by confirmatory testing. Regardless of high or low prevalence grouping, a patient with a repeatedly reactive HIV antibody screening test, confirmed by a positive Western Blot, has a probability greater than 99.75% of actual infection with HIV.[1]

HIV infection may be determined by two methods. The first is viral culture, specific when

positive. The virus will not be grown in 40 to 50% of infected individuals. Cost of viral culture and the significant precautions necessary have limited widespread use of this means of diagnosis.

The second method of determining HIV infection is serologic test. Most of the currently available testing systems measure IgG antibodies although IgM antibodies may also be present. Requirements for potency of detection systems have not been developed by the Food and Drug Administration. Specific IgM assay testing systems are available. Subsequent seroconversion to detect IgH antibodies is generally observed, although isolated case reports have demonstrated delays in excess of one year. After initial infection with the virus, there is a delay of several weeks before the antibody titers reach measurable levels. This "window" in which infected blood tests as negative to HIV antibody has been the usual cause of the rare instances of transmission of virus through blood transfusion. HIV antibodies usually appear within four to 12 weeks but occasionally prolonged periods have been observed prior to demonstrable antibody measurement. At the Third International Congress on AIDS, a study from Great Britian of 4 million blood donors revealed one transmission of HIV to a recipient. This individual was HIV antigen and IgG antibody negative.

ELISA screening antibody tests require skill in performance and interpretation. Methodologies of the seven approved FDA testing systems are no more complex than other comparable laboratory tests. Where the demand is significant, test reliability and turnaround should present no problems and should easily meet the needs of the medical community.

Confirmatory testing ● The sensitivity and specificity of the confirmatory Western Blot test may vary even in experienced laboratories. Technical demands are more complex, methodologies are less standardized and interpretation more subjective.

The Western Blot confirmatory HIV antibody test measures IgG antibodies by a different methodology. Puried viral antigens are separated by electrophoresis and serologic testing is performed on the isolated viral antigens. Antigens are HIV proteins or glycoproteins of varying molecular weight. They are designated as "p" for protein and "gp" for glycoprotein. Numerical designation represents molecular weights in Daltons. Antibodies to these specific core and envelope proteins provide the basis for the Western Blot test. Antibodies to core protein p15, p18, p24, p55, and envelope proteins gp41, gp120 and gp160 are most readily demonstrated. A positive test must demonstrate the activity to at least two bands and include one or more envelope antigens. Unfortunately, not all laboratories use the same criteria for a positive test. Now that the FDA has licensed the first test system, it is hoped that a national standard for Western Blot interpretation will be developed in the near future.

Other confirmatory tests may be mentioned for completeness. The indirect immunofluorescence assay (IFA) is used by several state health laboratories as a confirmatory test. Serum reacts with HIV infected cells obtained by tissue culture. HIV antibodies attach to infected cells and are detected by fluorescence microscopy.

The radioimmunoprecipitation assay (RIPA) is a less frequently used confirmatory test. This is lengthy and requires specific expertise. It is a procedure primarily used for research purposes. Some authorities feel that this test is a more sensitive confirmatory test than the Western Blot and may be indicated if equivocal results present a problem.

Second generation confirmatory tests ● Genetically engineered recombinant or synthetic peptides serve as the antigen basis for a group of "second generation" enzyme immunoassays. The subjectivity of the Western Blot determination is avoided. There is current optimism that both screening and confirmatory methods may evolve.

Antigen tests ● HIV antigen tests have been the subject of extensive investigation. Antigens may appear as early as two weeks after infection. It has been hoped that they will enable diagnosis in the initial "window" after infection and prior to antibody development. The viral core antigen p24 is used in the testing system. To date, the test system lacks the sensitivity and specificity to serve as a screening procedure.

Recent publications have suggested that increases of HIV antigens after antibody demonstration is association with development of ARC or AIDS. Conversely, patients who do not demonstrate antigen recurrence are less likely to develop AIDS. Further studies are necessary in this area.

The antigen test is useful in monitoring the effectiveness of AZT therapy. Decreased antigen levels indicate diminished viral replication and are presumptive evidence of a therapeutic response.

Pediatric HIV testing ● The application of the HIV testing sequence in pediatrics may vary somewhat. Transplacental passage of maternal IgG antibody may cause a positive HIV antibody test for several months after birth. IgM antibody which would assist in differentiating fetal and maternal antibody unfortunately is not present in infants with HIV infection. Viral cultures may be necessary to confirm the diagnosis when the clinical indications are suggestive of AIDS.

Testing rational ● The Centers for Disease Control has established three strategies for HIV antibody testing: (1) voluntary and anonymous, (2) voluntary and confidential, (3) mandatory and/or legislated. HIV antibody tests are used for screening, case finding and diagnostic purposes, depending on the manner in which the test is instituted and who benefits from the test results.

Screening methodology implies voluntary testing

of asymptomatic people who may benefit from the knowledge of positivity and early diagnosis. Screening programs may be mandatory. Mandatory programs have involved donors of blood, semen and organs for transplantation, the military, immigrants and federal prisoners. Mandatory screening cannot be anonymous but confidentiality of results is essential. Mandatory testing of blood donors to avoid transmission of HIV positive units of blood has been one of the great success stories of the HIV era.

HIV testing as a component of case finding occurs when a person considered at increased risk presents for one purpose and is tested for another disease. Drug abuse and sexually transmitted disease clinics demonstrate a high incidence of HIV positivity as a collateral finding.

HIV antibody determinations are but one of the numerous serologic tests for viral disease that have been utilized clinically for years. Signs and symptoms suggestive of immunodeficiency are becoming routine in many areas. Peripheral or central nervous system complaints, adenopathy, fever, diarrhea, and weight loss are among the numerous presenting features that may indicate the need for HIV antibody determination. In these instances, the testing sequence is an integral component of the management of the patient. The decision to test in this instance rests with the patient and physician. Pre- and post-test counseling, is essential. The essential components of HIV antibody counseling will be presented in the FMA Physicians Manual. The professional team is charged with the responsibility to assure individual rights to confidentiality of test results. Since introduction of the HIV antibody test in early 1985, much has been done to assure the individual rights of those found to be infected with the virus. Breech of confidentiality may be associated with diminished access to insurance, housing and job security. Antidiscrimination statutes are in place in several states or under consideration by many state legislatures.

Semantics of "confidentiality" can be confusing. All medical records including diagnostic test results are confidential. Diagnostic aspects of dread diseases must be conveyed to medical decision makers. There is always the potential for breech of confidentiality but examples are difficult to find. Medicine has handled the challenge to date but assurances must be absolute.

Summary • HIV antibody testing provides consistently reliable data when utilized in the proper testing sequence.

Screening (ELISA) test results were initially designed to prevent usage of blood products contaminated by the HIV virus.

As currently utilized in clinical practice, all screening positive HIV antibody tests must be confirmed by one of the recognized tests such as Western Blot prior to application in clinical decision making.

Application of test results in the best interest of the patient and society at large presents a major challenge. Whether to test or not is a decision ultimately to be made by the citizens of this country.

Bibliography

1. Bayer, R., Levine, C., and Wolfe, S.M.: HIV Antibody Screening: Ethical Framework for Evaluating Proposed Programs, JAMA 256:1768-1774, 1986.
2. Bohigian, G.M. (I-87): Accuracy of ELISA and Western Blot Serologic Tests for HIV Infection (Report: D), American Medical Association.
3. Centers for Disease Control: Predictive Value of Positive HIV Antibody Tests, MMWR 36:14S, 1987.
4. Henry, K.; Willenbring, K., and Crossley, K.: Human Immunodeficiency Virus Antibody Testing, JAMA 259:1819-1822, 1988.
5. Kessler, H.: Blaauw, B.; Spear, J., et. al.: Diagnosis of Human Immunodeficiency Virus Antibody Testing, JAMA 259:1819-1822, 1988.
7. Nelson, A.R. (I-87): AIDS Status Report; Highlights of Third International Conference on AIDS (Report: R), American Medical Association.
8. Saah, J.: Serologic Tests for Human Immunodeficiency Virus (HIV): Information on AIDS for Practicing Physician, AMA 2:11-13 (July), 1987.

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Blood Exposures: A Community Hospitals Approach

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Health care workers (HCWs) have been exposed through needlesticks and splashes of potentially infectious body substances into their eyes, mouth or non-intact skin from infected patients since the beginning of formalized health care. However, it was not until the appearance of hepatitis B in the late 40s that formalized documentation of illness as a result of such exposures was noted. Hepatitis B is currently the major infectious occupational health hazard in the health care industry and serves as a model for demonstrating transmission of blood-borne pathogens. The Centers for Disease Control (CDC), Hepatitis Branch, estimates that 500-600 HCWs whose job entails exposure to blood are hospitalized annually due to exposure to hepatitis B (HBV) and hepatitis non-A non-B.[1] There are over 200 deaths a year in HCWs, 2-15 from fulminant hepatitis, 170-200 from cirrhosis, and 40-50 from liver cancer. Studies indicate that 10% to 40% of health-care or dental workers may show serologic evidence of past or present HBV infection.

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Since recognition in 1981 of AIDS, caused by another blood-borne pathogen, human immunodeficiency virus (HIV), surveillance of HCWs for possible blood exposures has occurred. As of November 1987, only 14 incidents (1981-1987) of occupationally related exposure to HIV have been documented in the medical literature and through CDC studies. To date, overt illness has not developed in any of these individuals.[2]

Identification of similar modes of transmission of HBV and HIV in the health care setting demonstrates that the risk of HBV infection, subclinical, and clinical, including death, far exceeds that for HIV infection.[3,4] The risk of acquiring HBV infection following puncture with a needle contaminated by an HBV carrier is estimated as 6% to 30% while the risk of HIV following the same type of incident in less than 1%.[3,5]

Despite this type of epidemiologic information HCWs continue to be more concerned and fearful of HIV than HBV.

Objectives • The objectives of this project were fourfold:

I. To do a literature search and review some of the current relevant articles for more facts to support statements made in the introduction, especially in regards to HIV.

II. To determine more specific epidemiologic data as to how, where, when and to whom blood exposures happen in the health care facility where the authors work.

III. To compare the information obtained in objective II to that identified in a CDC study.

IV. To compare two separate time periods, one before full awareness of possible HIV exposure to HCWs to one after, and also to summarize a survey done in July 1985 to this data. The data used were collected in the health care facility where the authors work.

Summary of objective I ● Twelve relevant articles were identified. Following are brief summaries of four:

1. Discussed an ongoing surveillance project conducted by CDC which involves 883 HCWs known to have had blood exposure to a known HIV infected patient. Of the 883, 708 (80%) were from needlesticks and 175 (20%) from splashes. Five hundred thirty seven (61%) were in nurses, 32 (15%) in physicians, 159 (18%) in laboratory personnel, including phlebotomists, 36 (4%) in respiratory care therapists, and 19 (2%) in housekeeping/maintenance personnel. Locations included 538 (61%) on the nursing unit, 152 (17%) in the intensive care unit, 99 (11%) in the operating room, 59 (7%) in the laboratory, and 35 (4%) in the emergency department. Four HCWs have seroconverted, one is not included in the conversion rate due to the identification of another risk factor. The three seroconversions (0.9%) occurred from the percutaneous or needlestick group. Of total needlestick exposures 37% were preventable if proper disposal procedures are followed, specifically no recapping (recapping was responsible for 20% of the incidents) and placement in designated containers opposed to the trash can, floor, etc.[6]

2. Discussed a study conducted by the National Institutes of Health. As of April 30, 1987, 322 HCWs with 453 exposures to known HIV infected patients (103 needlesticks and 229 splashes) have been serologically followed with the HIV antibody test and no seroconversions have occurred.[7]

3. Discussed a study at San Francisco General Hospital. Three hundred forty-two blood exposures from known HIV infected patients (129 needlesticks and 213 splashes) occurred in 154 HCWs. No seroconversions noted.[8]

4. Discussed a study conducted at UCLA School of Medicine surveying for risk of HBV, HIV and herpes simplex-2 (HSV-2) infections in HCWs caring for HIV infected patients. Two hundred forty-six HCWs were followed with no HIV seroconversions, and one each for HBV and HSV-2.[9]

Summary of objective II ● Data were collected for five out of 11 months of 1987 on all blood exposures reported to the hospital employee health office. The purpose was to ascertain where, when and to whom do they occur as well as any involvement with known HIV infected patients. A total of 85 blood exposures were reported (78 percutaneous or needlestick, 92%, and seven splashes, 8%) with only four being known to HIV infected patients.

The following is a breakdown by location:

41 (48%) on nursing units
12 (14%) in intensive care units
16 (19%) in operating rooms
2 (2%) in laboratory
9 (11%) in emergency department
4 (5%) other

Following is a breakdown by professional occupation:

59 (69%) RNs
2 (2%) physicians
12 (14%) laboratory personnel
1 (1.2%) respiratory technician
7 (8%) maintenance/housekeeping
4 (5%) other

At least 26 (31%) were believed preventable if proper procedures are followed, specifically disposing syringes without recapping, 15/78 (19%) and 11/78 (14%) from improper disposal. An additional 16/78 (21%) occurred while performing intravenous procedures such as inserting or removing the needle or connecting or disconnecting a piggyback solution.

Summary of objective III ● Although information from the CDC study summarized under objective I deals with exposures to known HIV infected persons and the data from my hospital (reflected under objective II) deal with all documented blood exposures, the authors believed it worthwhile to compare some of the data.

	CDC Study	Community Hospital
Needlesticks	708 (80%)	78 (92%)
Splashes	175 (20%)	7 (8%)
RNs	437 (61%)	59 (69%)
Nursing unit	538 (61%)	41 (48%)
From recapping	140 (20%)	15 (19%)

There is no significant difference in any of the categories compared. Even though the numbers in the community hospital are small they have been reported in other findings, both from published and unpublished data, not inclusively referred to in the content of this paper.

Summary of objective IV ● The two time periods selected for comparison were January - March 1986, and January - March 1987. Even though HCWs in this hospital were becoming aware of HIV infected persons by early 1986 the numbers of known patients were small. As 1986 progressed intensive education was done and the numbers of patients seen were increasing. The data reflected here address exposures believed

preventable if appropriate procedures are followed. The purpose of the comparison was to determine if increased awareness impacted the reporting of blood exposures.

	Jan.-Mar., 1986 (Period I)	Jan.-Mar., 1987 (Period II)
Total number	28	54
Recapping	6 (21%)	12 (22%)
Improper disposal	3 (11%)	6 (11%)
IV related	5 (18%)	13 (24%)

Although the percent of the types of needlestick injuries remain the same there is almost a 100% increase, or a doubling of the number of incidents reported. It is believed that more injuries are being reported due to fear of acquiring HIV.

Additional findings:

1. In Period I no "splashes" were reported compared to seven in Period II.
2. As a result of the exposure protocol being instituted, following the report of a blood exposure, two patients involved in incidents reflected in Period II were found to be silent HBV carriers and appropriate prophylaxis was administered. It is difficult to determine if these would have been found had the importance of reporting not increased.

A survey of nursing personnel was conducted in July 1985 to determine a needlestick history of those participating. The survey method did not define time periods but only asked, "Have you ever had a needlestick injury."

The results of the needlestick injury survey were as follows:

Of the 163 responses (30%), 107 people stated they had been stuck by needles at least once. Some had multiple sticks with a total of 138. Of the 138 sticks: 78 (57%) were from recapping (73% when only counting one needlestick per person 78/107); 28 (20%) were from tasks; 5 (4%) were needles in the trash; 5 (4%) breaking after use; 8 (6%) needles in nurses pockets coming uncapped, and 14 (10%) other.

The major points determined by this survey were:

1. Identified major causes of needlestick injuries.
2. Supported the hypothesis that most needlestick injuries are not reported.
3. The survey method did allow for the data as presented to be compared to that of the two time periods.

Findings ● After reviewing information gleaned from completion of the objectives of this project, the authors believe the following statements are relevant:

1. Introduction of HIV (AIDS virus) into our health care facilities has created a greater awareness of a HCW's possible exposure to a serious infectious agent even though data support a more likely exposure to the hepatitis B virus.
2. Education and general awareness have made the HCW more conscious of the importance of reporting blood exposures. Even with the increased amount of reporting the causes of needlesticks remain constant while the importance of considering a "splash" as a possible exposure are just beginning to be recognized.
3. By identifying the causes of blood exposures additional methods of intervention and prevention can be developed and those already in place can be enforced.
4. From those causes identified at this institution and found to be comparable to the findings of others, anywhere from 22% to 57% of blood exposures could be prevented, as follows:
   a. 22% from recapping by providing rigid containers close to the site of use and/or teaching alternate methods of recapping.
   b. 11% from improper disposal (usually in trash) by educating and/or reminding personnel of appropriate disposal procedures.
   c. 24% from IV related procedures by evaluating and if indicated utilizing new products being developed.

Conclusion ● The need for surveillance of blood exposures and provision of education through various formats will be an ongoing activity of designated personnel to insure HCWs are not unnecessarily exposed to potentially infectious agents.

References

1. Department of Labor: Joint Advisory Notice; Department of Labor/Department of Health and Human Services; HBV/HIV, Federal Register, Vol. 52, No. 210, October 1987.
2. Centers for Disease Control: Recommendations for Prevention of HIV Transmission in Health-Care Settings, MMWR 36 (25): 1S-16S, Aug. 21, 1987.
3. Centers for Disease Control: Recommendations for Preventing Transmission of Infection with Human T-lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus in Workplace, MMWR 34:681-86, 691-95, Nov. 15, 1985.
4. Vlahov, D. and Polk, B.F.: Transmission of Human Immunodeficiency Virus Within the Health Care Setting, Occup. Med. State of Art Reviews 2:429-450, 1987.
5. Centers for Disease Control: Update-Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients, MMWR 36:285-89, May 22, 1987.
6. McCray, E.: Cooperative Needlestick Surveillance Group. Occupational Risk of Acquired Immunodeficiency Syndrome Among Health Care Workers, N. Engl. J. Med. 314:1127-1132, 1986.
7. Henderson, D.K.: Saah, A.J.: Zax, B.J., et al.: Risk of Nosocomial Infection with Human T-cell Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus in Large Cohort of Intensively Exposed Health Care Workers, Ann. Intern. Med. 104:644-647, 1986.
8. Gerberding J.L.; Bryant-LeBlanc, C.E.; Nelson, K., et al: Risk of Transmitting Human Immunodeficiency Virus, Cytomegalovirus, and Hepatitis B Virus to Health Care Workers Exposed to Patients with AIDS-related Conditions, J. Infect, Dis. 156:1-8, 1987.
9. Kuhls, T.L., et al: Occupational Risk of HIV, HBV and HSV-2 Infections in Health Care Personnel Caring for AIDS Patients, Am. J. Pub. Health 77:1306-1308, 1987.

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AIDS and Children

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The problem of children and AIDS encompasses those issues of the adult disease with a differing presentation and clinical course; the societal implications generate an even greater emotional intensity in consideration of the school environment and paucity of support systems available. There appears to be other distinct features such as significance of seropositivity, immunologic aspects, and influence of growth and metabolic factors.

HIV has been isolated from blood, semen and cervical secretions, in relation to the modes of transmission associated with pregnancy and neonatal transmission. The pregnant patient's means of HIV acquisition include exposure as an intravenous drug user, blood product recipient, and sexual partner of an infected individual. The chances of transmission of the virus to this group vary with type of exposure and immunity of the individual. Many of these patients were unaware of their seropositivity though pregnancy can cause acceleration of the disease.

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An infected woman has a 20-60% chance of passing the infection to her child, but recently it has been discovered that seropositivity in newborns may not have the same significance as for adults. Antibody acquisition by neonates in some cases may denote protection rather than be synonymous with development of the disease AIDS, but enough individuals will have to be followed. Similarly, seropositivity may be solely a result of maternal-fetal transfer and only transient in nature. The significance of seropositivity in these cases may depend on time alone to clarify the phenomenon. Possible factors may include the source of the mother's infection and, in the case of blood products, preparation techniques prior to transfusion.

Diagnosis • Without an indication to perform testing, such as known maternal infection, the diagnosis of pediatric HIV disease becomes more complex. Lack of seropositivity does not preclude the diagnosis of AIDS in adults or children, but in children other immunodeficiency syndromes, primary or secondary, must be excluded. In addition, there are other congenitally-acquired infections, such as CMV, toxoplasmosis, and herpes simplex, which are not necessarily associated with AIDS. Laboratory diagnosis includes CBC, quantitative immunoglobulin assays, liver function tests, chest x-ray and HIV antibody testing. Anemia and liver enzyme elevations are the most common abnormalities. Some children will actually have a normal ratio of helper to suppressor T-cells, though quantitative T-helper cells are diminished.

The presence of many of the adult opportunistic infections of AIDS can assist in diagnosis, but there are distinct diseases which are peculiar to the pediatric presentation. Such an entity is chronic lymphoid interstitial pneumonitis (LIP). Progressive neurologic disease secondary to primary HIV central nervous system infection is also more pronounced in children and can account for developmental abnormalities, microcephaly, seizures and encephalopathy. Immune thrombocytopenia as the sole manifestation of HIV infection has also been demonstrated. Frequent infections with Hemophilus influenza and pneumococcus

can be encountered, but again do not alone connote HIV infection. Failure to thrive may be the first presentation of the illness; infection and/or malabsorptive gastrointestinal etiology can be the cause.

Pneumocystis carinii pneumonia is seen, but Kaposis sarcoma and B-cell lymphoma are rare in children. Hepatitis B is also less frequent in children, and an acute mononucleosis-type presentation is rare. Disseminated CMV infection and varicella are particular threats to these children. Hepatitis B is also less frequent in children, and an acute mononucleosis-type presentation is rare. Disseminated CMV infection and varicella are particular threats to these children.

Treatment ● The value of available treatment modalities is many times offset by toxicity, cost and noncompliance. Immunoreconstitution or immunopotentiation approaches which include bone marrow transplantation thymic hormones, interferons, interleukin-2, gammaglobulins and enkephalins are not in general encouraging for control of HIV infection itself. Antibiotics are used for bacterial superinfection when indicated, but development of bacterial resistance and side effects is a consideration for their judicious use. Intravenous gammaglobulin has been successful in the reduction of bacterial infection, but cost, lack of agreement on optimum dosage and selection of the appropriate HIV-infected patients have precluded widespread use. Hyperimmune serum has shown value mostly in the realm of prevention, possibly for use in HIV-infected women during early pregnancy. Antiviral agents are employed, especially in the face of viral CNS infection. Side effects are a major drawback as is the apparent antagonistic effect of different antiviral agents on each other. Combinations of viral and immunopotentiating agents have also been studied.

Other manifestations ● Some aspects of pediatric infection have changed, and these will no doubt impact on the numbers and types of childhood manifestations of HIV infectivity. At this point, we are experiencing the effect of HIV-infected children who are largely the product of blood transfusion-related transmission. With blood screening and pretransfusion preparation, a majority of these cases will be eliminated. The biggest variability lies with the remainder of maternally-transmitted infections. It was thought that these children might die or be too sickly to enter the school system, but other factors, including maternal factors such as prenatal care and gestational age, significance of seropositivity at birth, individual latent periods in the evolution to the disease AIDS, response to various treatments and host immunity, have countered this.

As a result, we must deal with a myriad of intertwined medical, social, educational and emotional issues. The lack of psychological support systems for many of these children is a major limitation to their adjustment to the school environment. Violation of their right to confidentiality precludes the enrichment normally encountered within the realm of education and peer interaction. Guidelines have been established for proper integration into the classroom setting. This consists of a team approach to assessment and periodic monitoring of the child, his or her family/support structure, preferences, needs, health status and psychosocial adjustment. Regardless of the presence or absence of HIV-infected children within a given community, proper education is critical to counteract and address the misinformation and anxiety which result in the rejection of these human beings, and their loss of dignity and self-esteem.

References

1. Report of the Surgeon General's Workshop on Children with HIV Infection and Their Families, U.S. Department of Health and Human Services, DHHS Publication No. HRS-D-MC 87-1.
2. MMWR, January 29, 1988, Guidelines for Effective School Health Education to Prevent the Spread of AIDS.
3. MMWR, December 18, 1987, Human Immunodeficiency Virus Infection in the U.S.
4. Informational Report of Council on Scientific Affairs — Pediatric Acquired Immunodeficiency Syndrome — AMA.
5. Recommendation Concerning Immunocompromised School Children, AMA.
6. Health Guidelines for Attendance in Daycare and Foster Care Settings of Children Infected with Human Immunodeficiency Virus, Pediatrics, March 1987.

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AIDS and Drug Abuse

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The National Institute on Drug Abuse has estimated that 1.2 million Americans inject themselves with illegal drugs. Their HIV infection rate is increasing and it is predicted that drug abusers are likely to become the main transmitters of AIDS in the future.[1] This statement appears to have merit because intense education efforts appear to be effective in modifying the sexual behavior of the high-risk homosexual population. This is clearly not the case among drug abusers.

Most epidemiologists estimate that approximately 50% of intravenous drug abusers will become seropositive for HIV within the next five to seven years.[2] Should this prediction hold true, the medical profession will face an even greater epidemic than challenges us now. The sharing and repeated use of needles, syringes and other drug paraphernalia are known to be direct vehicles for the spread of HIV. More than 95% of intravenous users including those who regularly inject heroin or who periodically inject other drugs such as cocaine or amphetamines, regularly share their needles.[3] Small amounts of contaminated blood left in needles and syringes carry the AIDS virus from one user to another. More than 80% of cases of AIDS in women are associated with intravenous drug abuse. However, it is important to point out that an increasing number of cases of AIDS in women without an intravenous drug history is being noted. Sexual relations with an infected intravenous drug user has been shown to put the nonuser at risk as well. If that nonuser is a woman, and she becomes infected, the risk of another transmission through sexual intercourse goes on. Should she become pregnant, her unborn child may become infected as well. The Centers for Disease Control has reported that the sexual transmission of AIDS virus from women to men is documented in the United States.[4]

Mood-altering drugs ● It is important to point out that the abuse of mood-altering drugs including alcohol may play an indirect role in the epidemiology of AIDS. The disinhibiting effect of marijuana, alcohol, cocaine, amphetamines and prescription drugs can lead to participation in high-risk sexual activity. An unsuspecting participant, under the influence of a mood-altering chemical, may engage with seropositive carriers. Females may become engaged in sexual activity with males who, unbeknownst to them, are IV drug abusers or HIV carriers. Males under the influence of drugs may become engaged in high-risk behavior with male or female prostitutes. Should these potential victims of the disease be part of a marital relationship, another innocent victim is at risk for infection.

It is also known that alcohol and other mood-altering drugs have a negative effect on the human immune defense system.[5] To what degree this fact contributes to the progression of full-blown AIDS in seropositive carriers who abuse drugs is not known. Scientific studies are planned to shed more light on

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this subject. In addition to the toxic effect of alcohol and other mood-altering drugs on the immune system, poor nutrition which results from chronic or episodic drug abuse may also indirectly contribute to compromise of the body's immune system and enhance the progression of HIV infection.

Behavioral changes ● Traditional medical and educational approaches to encourage behavioral change in drug abusers have generally been unsuccessful. Since all mood-altering substances have their major effect on the brain, it is not reasonable to expect that drug abusers will be able to "learn" through simple educational methods. In the addicted individual, the drugs cause changes in the brain which lead to strong compulsive behaviors. Thus, strategies designed to prevent the spread of the AIDS virus in drug abusers must include a multifactorial approach. The admission of drug abusers into chemical dependency units employing a comprehensive medical model of addiction treatment will help to decrease the spread of AIDS.[6] However, it is estimated that only one out of every seven to ten actively addicted patients is receiving professional treatment. While we are waiting for the development of widely available and readily accessible treatment programs, the medical profession must continue to work together with private and governmental agencies in order to implement AIDS prevention strategies in the drug abusing population, regardless of economic status. The recruitment and training of workers who would be willingly dedicated to intervene upon the street population as well as the affluent drug abusing population has been proposed.[7] Other temporizing prevention strategies such as methadone clinics, "safe needle use" techniques, and free access to clean needles have been implemented in a few high-risk areas. However, full participation in these efforts by the medical profession raise moral, ethical and possible medical-legal questions which need to be resolved. The Florida Medical Association through its Committee on Substance Abuse and Ad Hoc Committee on AIDS is vigorously pursuing the study of a variety of modalities to stem the tide of the major health program of drug abuse and AIDS.

References

1. Weinberg, D. S. and Murray, H. W.: Coping with AIDS, New Engl. J. Med. 317: 1469-1473, 1987.
2. Thomas, P.: Second Wave of AIDS: IV Drug Abuers and Their Kin, Medical World News, January 11, 1987, pp. 76-77.
3. Korcok, M.: AIDS and Chemical Dependency, Published by Health Communications, Inc., Pompano Beach, Florida 33069.
4. Mondenaro, J.: Strategies for AIDS Prevention: Motivating Health Behavior in Drug Dependent Women, MMWR 19:143-149, 1987.
5. Flavin, D. K.: Alcohol and the Human Immune Defense System: National Council on Alcoholism Medical/Scientific Advisory Paper, Washington, D.C., January 1987.
6. Clark, H. W. and Washburn, P.: AIDS Antibody Testing in Chemical Dependency Treatment Program, California Society for Treatment of Alcoholism and Other Drug Dependencies News 14 : 1-8, 1987.
7. Stein, J. B. and Branson, B. M.: New AIDS Prevention Strategies for IV Drug User, Focus, A Guide to AIDS Research 2: 1-3, 1987.

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Infected Patients: Psychosocial-Psychiatric Needs

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There is a tremendous effort underway within the medical and scientific communities to effect prevention and treatment modalities for the physical components of the virally-induced illness of AIDS. A similar thrust is necessary by medical professionals to deal with the emotional-social consequences of this devastating illness. No matter whether the patient be a gay homosexual male or female, an IV drug abuser, a hemophiliac child, or a posttransfusion victim, the psychological impact of the disease can be enormous. This fact is also true of loved ones, spouses, family members, and treating professionals who also may be emotionally affected by the illness. Therefore, it is recommended that the treatment of AIDS patients and their significant relationships include a comprehensive psychosocial component. It is also recommended that health care workers involved in this highly stressful area of medical care themselves receive emotional support in order to deliver the best objective care possible.[1]

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When a diagnosis of HIV infection is made, several symptoms may emerge acutely and/or chronically. These include anger, guilt, confusion, anxiety, depression, low self-esteem, preoccupation with the illness and probable death, loneliness, self-pity and the fear of total alienation. It is now known that emotional therapeutic models can effectively treat these symptoms. It is also known that without help, AIDS patients are at increased risk for suicide.[2]

As part of a psychosocial evaluation, it is important to remember that mental disorders commonly seen in AIDS patients which include delirium, dementia, personality and mood disorders may have an organic basis. Before primary psychological or psychotherapeutic modalities are employed, evaluations for primary CNS infection, mass lesions including neoplasm, and vitamin depletion states should be completed. Consultations from specialists in these areas are appropriate. This information will be helpful to determine if the abnormal emotional symptoms expressed by the patient are due to a primary organic cause or are secondary to psychological stress factors.

Multidisciplinary services ● Once physical-structural lesions are ruled out, a comprehensive program to meet the psychosocial needs of the patient and the family may be instituted. The provision of these services usually requires a multidisciplinary team which includes dedicated medical and mental health professionals knowledgeable about the special needs of AIDS patients and their families. It is recommended that the psychological-support and treatment team maintain communication with the primary physical care physician and consultants throughout the course of the patient's illness. This is extremely important in order that communication to the patient and his family be fully accurate, up-to-date and uniform. This

will reduce stress upon the patient and his family and upon the health care team as well.[3]

Comprehensive AIDS treatment centers are utilizing multidisciplinary services which include psychiatry, psychology, group therapy, family support counseling, social services, clergy and primary care physicians. Screening for the individual needs of the patient and loved ones will allow the orchestration of individual treatment plans. Because AIDS is a potentially fatal disease, services should be available beyond terminal care and include postbereavement support. Serious and final decisions concerning care for the dying patient, terminal measures, resuscitation, nursing home placement, hospice care, and even funeral arrangements and legal matters are best made with a team approach and can include the wishes and input of the patient and his loved ones.[4]

Fears about transmission of the disease to family members and loved ones, premature death and dying, loss of income and stigmatizing pressures from the community are issues which face AIDS patients and their relationships. The utilization of a comprehensive professional team approach together with volunteer community groups is thought to be a vital adjunct in the overall management of AIDS patients and their families.

References

1. Kubler-Ross, E.: AIDS: The Ultimate Challenge, McMillan Press, 1988.
2. Marzuk, M., Tierney, Helen, et al: Increased Risk of Suicide in Persons with AIDS, JAMA 259:1333-1337, 1988.
3. Keeling, R.P.: Effects of AIDS on Young Americans, Medical Aspects of Human Sexuality, September, 1987, pp. 22-23
4. Frierson, R.L. and Lippmann, S.B.: Psychological Implications of AIDS, American Family Practice 35: 109-116, 1987.

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Human Immunodeficiency Virus Infection in a Rural Community

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***ABSTRACT:** To evaluate the AIDS problem in Belle Glade, Florida, a rural community with a high incidence of the disease and a high proportion of cases with no identifiable risk factor, initial seroprevalence studies of the human immunodeficiency virus (HIV) were conducted in 1985. In a community-based study, one (6%) of 17 participating adults had antibody to HIV. In a clinic-based study conducted at a local health center serving Belle Glade and nearby towns, 22 (8%) of 275 participants were seropositive; of 170 participants residing in Belle Glade, 19 (11%) were seropositive. Heterosexual contact with a person with AIDS or at increased risk for AIDS was the most commonly reported risk factor. There was no statistically significant association between antibodies to seven arboviruses and to HIV, suggesting that indigenous mosquitoes were not transmitting HIV to any detectable extent.*

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Ongoing surveillance in Florida shows a high cumulative incidence of acquired immunodeficiency syndrome (AIDS) reported from Belle Glade (806/100,000 population, 1981 through February 1, 1988) with the majority of cases in heterosexual adults. Serologic surveys of heterosexual, nonintravenous drug abusing groups in the United States generally have shown <1.0% prevalence of antibody to human immunodeficiency virus (HIV).[1,2] A 1986 population-based study in Belle Glade showed an overall seroprevalence of 3.2% in randomly selected participants, predominantly associated with transmission through heterosexual contact and IV drug abuse.[3] This paper presents HIV seroepidemiologic data collected from Belle Glade in 1985 when we conducted two studies to evaluate the AIDS problem and determine the feasibility of further investigation.

Background ● Belle Glade has an agriculture-based economy and is located in Palm Beach County approximately 45 miles west of West Palm Beach (Fig. 1). The 1980 U.S. Census estimated there were 16,500 year-round residents, 53% were black, 40% white and 7% other. The population varies in size and characteristic depending on the agricultural season. A central part of town is characterized by low socioeconomic status [4] and high rates of sexually transmitted diseases (STDs) and IV drug abuse. The Palm Beach County Public Health Unit provides public health and primary-care services to residents of Belle Glade and the surrounding area through the local Glades Health Center.

Through April 1985, 31 cases of AIDS had been reported from Belle Glade (Table 1), all in blacks and clustered in the central part of town. The relatively high cumulative incidence (188/100,000 population) and apparently high proportion (19%) of cases with no identifiable risk factor were hypothetically

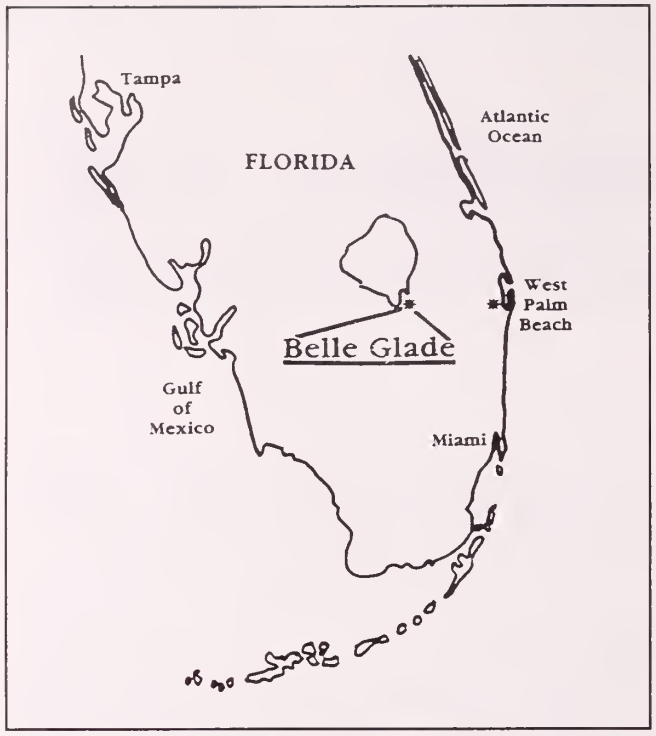

Fig. 1.—Belle Glade, Florida.

explained at that time by environmental (mosquito borne) transmission of HIV.[5]

Methods ● *Community Study.* A stratified random sample of 20 households were visited August 20-23, 1985, in the neighborhood with the highest concentration of reported AIDS cases. Informed consent was sought and participants were asked to give a whole blood specimen, submit to a brief physical examination, and respond to a detailed questionnaire on risk factors for HIV infection. Examinations and interviews were conducted in the privacy of a small motor home rented for this purpose.

Clinic Study. The primary objective of this study was to estimate the point prevalence of antibody to HIV in a clinic population of residents. In the six-week period beginning August 20, 1985, Glades Health Center clients scheduled to give a whole blood specimen (e.g., for blood chemistry, VDRL) and qualified to give informed consent in their own behalf were approached after phlebotomy. The study was explained to each one and a request was made to conduct further tests on an aliquot of the specimen already collected.

Informed consent was obtained at intake to the clinic study. All participants were provided information and education concerning transmission and prevention of HIV infection as well as implications of having a positive antibody test. Data on age, sex, race, city and length of time in residence, and country of origin were collected in a face-to-face interview. An abbreviated questionnaire, which excluded items on risk factors, was conducted with those participants who chose to be tested without knowledge of their serologic findings. For those choosing to receive their test results, a brief section of questions on risk factors was included, since this information was necessary for post-test counseling and interpretation of findings. Risk-factor prevalence was evaluated for such participants to help estimate sample size for further studies. Seroprevalence of antibody to HIV was determined according to demographic characteristics and risk factors. For seronegative participants, the prevalence of specific behavioral risk factors was determined.

HIV Serologic Testing. Split serum specimens were sent to the state (HRS) laboratory and to CDC, Atlanta, where they were examined independently for antibody to HIV by enzyme immunoassay (EIA). Specimens repeatedly reactive at either laboratory were further examined for antibody to HIV by Western blot assay[6] at CDC. In both studies seropositivity was defined as repeatedly reactive at both HRS and CDC by EIA and Western-blot-positive at CDC.

Testing for Antibody to Certain Arboviruses. A second objective of these studies was to assess the likelihood of HIV transmission via mosquitoes. For each specimen with sufficient serum, an aliquot was tested for antibodies to nine arboviruses, of which seven are indigenous to south Florida, one (Maguari) is related to an indigenous virus (Tensaw), and one (dengue 2) is currently indigenous to the Caribbean but not south Florida. It was assumed that antibody to a specific virus could be correlated with exposure to the principal arthropod vector of that virus. Specimens were tested by serum dilution-plaque reduction neutralization[7] for antibodies to the nine arboviruses: Tensaw, Maguari, Keystone, St. Louis encephalitis, dengue 2, Pahayokee, Shark River, Mahogony Hammock, and Gumbo Limbo. A positive finding was defined as a titer of $\geqslant$ 10 indicating infection at an unspecified time with that virus or a closely related one. To evaluate a possible association between exposure to mosquitoes and HIV infection, the prevalence of antibody to each arbovirus was determined according to HIV-antibody status.

Results ● *Community Study.* Of 20 adults approached, 17 (85%) consented to participate. Their mean age was 31 years, range 17-57 years; 71% were female; all were black. One (6%) serum specimen was positive for HIV antibody. It was from a 45-year-old Haitian-born male with a history of having sex with female prostitutes but no recognized behavioral risk factor for infection. At examination, he had symptoms suggestive of AIDS and was referred for further evaluation.

Clinic Study. Of 284 eligible persons approached,

Table 1.—AIDS Patients, by Risk Factor, Belle Glade, Florida, April 1985.

Risk Factor	Male	Female	Total	(%)
Homosexual/bisexual	3	0	3	(10)
IV-drug abuser	6	2	8	(26)
Homosexual/bisexual and IV-drug abuser	2	0	2	(6)
Heterosexual contact*	9	3	12	(39)
None of the above	6	0	6	(19)
TOTAL	26	5	31	(100)

*Includes two persons who had heterosexual contact with a person with AIDS or at increased risk for AIDS and 10 persons born in Haiti, where heterosexual transmission is thought to play a major role in the spread of HIV.

Table 2.—Prevalence of Antibody to HIV, by Age and Sex, Belle Glade Residents, Clinic Study, Florida, 1985.

	No. Positive/No. Tested (%)		
Age	Male	Female	Total
10-19	0/5	1/10 (10)	1/15 (7)
20-29	2/15 (13)	4/26 (15)	6/41 (15)
30-39	5/15 (33)	4/26 (15)	9/41 (22)
40-49	1/5 (20)	0/14	1/19 (5)
50-59	2/12 (17)	0/19	2/31 (6)
60-69	0/7	0/9	0/16
>70	0/5	0/2	0/7
TOTAL	10/64 (16)	9/106 (8)	19/170 (11)

275 (97%) agreed to participate. The mean age was 40 years, range 11-85 years; 65% were female; 88% black, 10% white, and 3% Hispanic; 62% resided in Belle Glade.

Both laboratories concurred in the findings of 271 (99%) of the 275 specimens tested by EIA for antibody to HIV. The prevalence of antibody to HIV was 8% (22/275). Seropositive participants were more likely to reside in Belle Glade than in other communities in the health center catchment area (19/170 vs. 3/105, odds ratio = 4.3, 95% confidence interval = 1.2 – 18.7). Further analysis of the clinic-based data was limited to the 170 Belle Glade residents, of whom 19 (11%) had antibody to HIV.

According to clinic of attendance, the seroprevalence was 15% (5/33) for the STD clinic, 11% (12/109) for the medical clinic (which also treated clients for STDs) and 4% (1/23) for the family planning clinic. Of five participants seen in other clinics, one had antibody to HIV; this was a tuberculosis clinic patient with a confirmed diagnosis of AIDS.

The sex-specific seroprevalence rates for Belle Glade residents were 16% (10/64) for males and 8% (9/106) for females (Table 2); the ratio of infection rates for males to females was 1.8:1. The age range of seropositives was 21-52 years for males and 17-34 years for females. Overall, the greatest number of infections and highest rate of positivity were found in persons aged 30-39 years, followed by those 20-29 years. No evidence of HIV infection was found in 23 persons aged 60 years or older. All 19 Belle Glade seropositive individuals were black, of whom 16 were born in the United States and three in Haiti.

All seropositive persons had been questioned on risk factors at intake. A risk factor for AIDS was identified in 12 (63%) of the 19 (Table 3). Of seven seropositive males, one was bisexual, one had received a blood transfusion, four had heterosexual contact with IV-drug abusers, and one was Haitian-born. Six of the seven also reported having sex with female prostitutes. Of the five seropositive females with a risk factor, one abused IV drugs, two had heterosexual contact with a person with AIDS, one had heterosexual contact with an IV drug abuser, and one was Haitian-born.

Of 48 seronegative males who responded to the series of questions on risk factors, seven (15%) reported heterosexual contact with an IV drug abuser, two (4%) were IV drug abusers, one (2%) was homosexual, and 18 (38%) reported sexual contact with a female prostitute. Of 75 seronegative females responding, four (5%) reported heterosexual contact with an IV drug abuser, one (1%) was an IV drug abuser, one (1%) reported sexual contact with a bisexual male, and nine (12%) reported having sex with men who had sex with prostitutes.

Arbovirus Data. Of 292 serum samples collected in the community and clinic studies combined, 257 (88%) were tested for antibodies to arboviruses. All arbovirus antibody findings were combined for analysis according to HIV antibody status, without regard to city of residence (Table 4).

HIV-seropositive persons were no more likely than HIV seronegatives to have detectable antibody to any of the listed arboviruses ($p > 0.1$ in each instance). Similarly, when analyzed for Belle Glade residents only, there was no association between antibody to HIV and antibody to any of the arboviruses for which tests were done (data not shown).

Discussion ● The finding of 11% overall prevalence of HIV antibody in a clinic population of Belle Glade residents confirms a high endemic focus of transmission consistent with the magnitude of the AIDS problem in that town. Heterosexual contact with a person with AIDS or at increased risk for AIDS was the most commonly reported risk factor for both male and female residents who were seropositive in the clinic pilot study. Although persons attending the health center clinics may not represent the population at

Table 3.—Persons with Antibody to HIV, by Risk Factor, Belle Glade Residents, Clinic Study, Florida, 1985.

Risk Factor	Male	Female	Total	(%)
Homosexual/bisexual	1	0	1	(5)
IV-drug abuser	0	1	1	(5)
Heterosexual contact*	5	4	9	(47)
Transfusion	1	0	1	(5)
None of the above	3	4	7	(37)
TOTAL	10	9	19	(100)

*Includes six persons who had heterosexual contact with a person with AIDS or at increased risk for AIDS and three persons born in Haiti, where heterosexual transmission is thought to play a major role.

Table 4.—Persons with Antibody to Seven Arboviruses Correlated with Antibody to HIV, Clinic and Community Studies, Belle Glade, Florida, 1985.*

	Antibody to HIV			
Arbovirus**	Pos. (N = 22)		Neg. (N = 235)	
Tensaw	1	(5%)	9	(4%)
Maguari	2	(9%)	17	(7%)
Tensaw and Maguari	1	(5%)	24	(10%)
Keystone	1	(5%)	37	(16%)
St. Louis encephalitis	1	(5%)	11	(5%)
Dengue 2	1	(5%)	13	(6%)
Pahayokee	0		10	(4%)
Shark River	0		2	(1%)

*257 (88%) of 292 serum samples available for these tests; residents of all cities included.

**None had antibody to Mahogany Hammock or Gumbo Limbo viruses.

large, similar characteristics among the identified HIV-infected participants and the reported AIDS cases suggest that HIV infection is not uniformly distributed throughout the community.

Age- and sex-specific HIV-seroprevalence rates in the study participants are consistent with those for STDs.[8] The high proportion of seropositives with no identifiable risk factor (37%) points to the need to clarify at-risk behaviors and exposures. However, the distribution of antibodies to arboviruses in HIV seropositives and seronegatives does not support the hypothesis of mosquito borne spread of HIV, a finding consistent with a later investigation.[3]

High rates of participation in studies indicated that further study of the problem was feasible. A large-scale, population-based seroepidemiologic investigation in Belle Glade was warranted, judging from the HIV infection rate for participants in these studies. Guided by these findings, the subsequent study[3] evaluated HIV seroprevalence by age, sex, and neighborhood. In addition, the prevalence of high-risk behaviors in susceptibles was determined to define populations at increased risk of HIV exposure. Strategies to intervene and reduce that level of risk are now being developed and implemented in the community.

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References

1. Schorr, J.B., Berkowitz, A., Cumming, P.D.; Katz, A.J., and Sandler, S.G.: Prevalence of HTLV-III Antibody in American Blood Donors, N. Engl. J. Med. 313:384-385, 1985.
2. Centers for Disease Control. Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Antibody Prevalence in U.S. Military Recruits, MMWR; 35:421-424, 1986.
3. Castro, K.G.; Lieb, S.; Jaffe, H.W. et al: Transmission of HIV in Belle Glade, Florida: Lessons for Other Communities in United States, Science 239:193-197, 1988.
4. U.S. Bureau of the Census, 1980 Census of Population and Housing Neighborhood Statistics Program: Narrative Profiles of Neighborhoods in Belle Glade, Florida, U.S. Government Printing Office, Washington, D.C., 1983.
5. Whiteside, M.E., Withum, D.; Tavris, D., and McCleod, C.: Outbreak of No-Identifiable-Risk Acquired Immunodeficiency Syndrome (AIDS) in Belle Glade, Florida, Presented at the International Conference on AIDS, Atlanta, April 17, 1985.
6. Ward, J.W., Grindon, A.J., Feorino, P.M., et al. Laboratory and Epidemiologic Evaluation of Enzyme Immunoassay for Antibodies to HTLV-III, JAMA, 256:357-361, 1986.
7. Lindsey, H.S., Calisher, C.H., and Mathews, J.H.: Serum Dilution Neutralization Test for California Group Virus Identification and Serology, J. Clin. Microbiol. 4:503-510, 1976.
8. Centers for Disease Control, Annual Summary 1984, MMWR 33:24,60, 1986.

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Ethics in the Care of AIDS Patients

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Caring for patients infected with the HIV virus demands not only the physician's highest technical skill but his/her best ethical sensibilities as well. Both patients and public are afraid. Media attention has aroused anxiety but left many people confused. Health care workers, even doctors, are uncertain as to the best way to protect patients, the public and themselves. In such a context many long-standing ethical issues present themselves with special impact. Those considered here will be:

1. Obligation to treat
2. Requirement of testing
3. Protection of confidential information
4. Notification of third parties at risk
5. Notification of other health care workers
6. Protection of caregivers
7. Caring for the terminally ill
8. Patient requests for assistance in suicide
9. Provision of compassionate care

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1. Are physicians obligated to care for patients who are HIV positive?

The AMA Council on Ethical and Judicial Affairs has spoken clearly on this question. "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive." Basing the decision to treat on the nature of the AIDS patient's disease is discriminatory. The obligation to avoid such discrimination overrides the doctor's right to choose whom to care for. When he/she is unable to provide services required by an AIDS patient the physician should make appropriate referrals.

Medical ethics is not just a matter of right acts. It also involves good attitudes and intentions. HIV patients challenge many physician attitudes. Gay patients may stimulate latent homophobia. Because lifestyle choices have brought on their illness it may be easy to blame these victims for being ill. Because some abuse drugs they may be thought lawless and self-destructive. Because virtually all will become indigent it may seem unprofitable to care for them. How can one feel good about caring for those who are not "nice people", "people like me"?

In addition, the act of caring for HIV patients is stressful. Other patients may be reluctant to see doctors who treat AIDS. Other physicians may even reduce referrals or refuse to share space lest their "clean" patients be tainted by associating with "soiled" ones. Doctors' spouses may believe their health and that of their children is at risk if the physician spouse cares for AIDS patients. "Why not let someone else take care of them?" they may ask.

And AIDS patients die. Doctors don't ever seem to win. Medicine is supposed to be about healing, curing. It is difficult to get as much satisfaction out of caring for terminally ill patients as for making patients well. The needs of the patients, families and other caregivers for emotional support are all directed at the doctor. A doctor may become emotionally bat-

tered as well. In the face of this pressure one can easily withdraw physically and stop seeing such patients or withdraw emotionally and cease to care, only treat. One can examine without listening, prescribe without counseling, or visit without consoling.

To choose to withdraw in either way is to choose to be less than one can be as a physician. Collectively the institution of medicine has the responsibility to meet the challenge of this terrible disease. If a few doctors opt out those in need will still be cared for. But if too many decide to let the other M.D. do it, those willing to help will be consumed by the burden. Ultimately the whole profession will be found wanting by its society and lose its claim to honor and privilege. The HIV crisis will put the whole idea of a profession in service to mankind to the test.

2. Under what conditions may patients be tested?

Testing should be available to all patients who seek it. Doctors should advise those in high risk groups to be tested. Anonymous testing is available through the health department. Testing should always be accompanied by compassionate and informative pre-test and post-test counseling.

Testing for all citizens not in prison or the military remains voluntary. Proposals for mandatory premarital testing have usually been rejected as not cost effective. Although testing is required of donors of blood and organs for transplant, their ability to elect not to donate protects the voluntary nature of the testing. They or, in the case of the no longer competent organ donor, their family members must be informed that HIV testing will take place.

Some offices and clinics want to protect their caregivers. They believe that if they can learn which patients are seropositive they can be sure that special precautions will be taken with those patients. To do this they must require all patients to be tested. Such requirement can be ethically permissible if it is not used as an excuse for refusing treatment and if the following conditions are met:

A. Patients must be clearly told that HIV testing is required. Performing such tests without informing patients is unethical.
B. Patients must have a private opportunity to give or refuse consent to testing.
C. Patients must be fully informed before being asked to consent. The consent procedure must meet the standards of full disclosure, patient understanding and voluntary choice.
D. Patients must receive pre-test and post-test counseling on the meaning of the findings of HIV tests.
E. Special precautions must be taken to keep test results confidential. (See section on confidentiality.)
F. A referral must be made to a caregiver willing to care for patients not wanting to be tested. If no referral is conveniently available, refusing to care for such patients effectively denies them care. This will create a problem only in small communities where other physicians or facilities are not available or in large communities if the testing requirement becomes widespread.

3. What is the confidentiality requirement for HIV infected patients?

Confidentially helps define the relationship between any doctor and any patient. It symbolizes patient trust for the doctor and the doctor's complete focus on the well-being of the patient. But confidentiality is of special importance for HIV infected patients. Unfortunately those patients experience much discrimination. The public's fear fed by media hysteria and conflicting reports has led employers to fire, patients to desert, families to reject, lovers to abandon, and friends to ignore those infected.

Because the consequences for patients are so potentially harmful, the knowledge of a patient's HIV positivity must be protected with an extra measure of concern. Some doctors, in order to insure confidentiality of testing, send patients to the health department's anonymous testing program rather than initiate the test themselves. Doctors are required to report an individual to the health department's STD program only when actual symptoms of ARC or AIDS appear.

Doctors would do well to discuss confidentiality with patients. They should be cautioned about the potential danger of revealing their positive status where it is not necessary to do so. Confiding carelessly, even in a good friend, may trigger gossip that can never be stopped. On the other hand patients have a responsibility to inform their sexual partners about their positivity and to suggest that those partners be tested.

4. Should third parties at risk be notified?

Occasionally a patient will refuse to tell sex partners. A doctor may then face a conflict between keeping the confidence and acting to protect identifiable, endangered third parties. Under such a circumstance the physician has a duty to warn either by contacting the partners directly or by informing the STD program of the health department.

But the doctor should act with caution. The problem should be seen in its context. Patients often need time to accept the diagnosis and its cruel consequences. In a few days the patient may agree to do what he would not agree to do immediately. Effective pre-test counseling will help set the stage for patients to agree to notify partners. Post-test counseling will also be helpful. It is usually possible to arrange for a same day visit to an AIDS counselor either through the health department or the AIDS network. This counselor can help the patient and can share some

of the burden with the doctor.

Even if doctors or counselors cannot convince patients to tell sex partners during an initial talk, they may be able to extract a promise either to avoid sex or to practice safe sex until a further session. Since a second test is required to insure against false positivity the doctor may want to set an appointment to draw the blood for that test after a lapse of 24 to 48 hours. Such a delay will give the patient a chance to recover from the shock of the positive result and the visit will provide an opportunity for further physician counseling. There is much information the patient needs in order to be able to deal with the condition, but there is also much emotion triggered by the test result. The patient needs help with the shame, fear, anger, and despair as well. When that has been accomplished the patient may be more willing to tell those who must know. Sometimes the patient may be willing to do so if the doctor agrees to be present.

If a physician determines that a patient will not share knowledge of positivity with sex partners the patient should be informed that the doctor intends to do so. If the doctor chooses to contact such a partner directly great care should be used to insure that the information is conveyed in a kind supportive fashion, in an appropriately private context. The inherent impersonality of letters and phone calls makes them undesirable.

5. Should other caregivers be notified?

Sometimes the question of sharing the patient's record with other caregivers arises. Patients must always consent to a transfer of their records. If the physician knows that the patient is seeing another caregiver and has not told that individual about his seropositivity, the doctor may have a duty to inform if the treatment given by the other caregiver involves a significant risk. Psychotherapy would not; oral surgery would. Again the patient must be told if the doctor decides to breach confidentiality.

Doctors should review their procedures for protecting information about all patients to determine what additional measures are necessary. The general rule has been that only health care workers who need the information in order to help the patient or to protect others should be permitted access to patient records. In practice many additional people have casual access to records; still others review them for billing, insurance, or quality review purposes. Not all these people may need such access. All who do should be carefully indoctrinated into the need to keep information private. Physicians may want to organize staff training sessions on this point. It also may be possible to keep independent files on seropositive patients. Care should be taken to avoid accidentally revealing a patient's status. If a doctor asks the receptionist for the phone number of the AIDS network while a patient is in the examining room the receptionist will have been told that the patient has AIDS!

6. How may caregivers protect themselves against acquiring the HIV virus?

Caregivers can ethically protect themselves in whatever ways are effective at times when the procedures they are performing put them at risk. Careful attention should be given to data on the risk of various procedures. On the other hand talking to, palpating, auscultating, observing, or otherwise touching HIV infected patients does not present risk. When caregivers wear special gloves, gowns, masks and goggles patients may conclude that they are regarded as pariahs. Using protective gear when it is not needed can contribute unnecessarily to patients' feelings of rejection. Patients should be told when and why protective measures will be taken. They badly need sensitive human care including touching, as well.

7. What is required in the care of terminally ill AIDS patients?

AIDS patients die. Those who care for them will face many of the same questions caring for terminally ill AIDS patients that they do facing patients terminally ill from other diseases. Sometimes it seems difficult to care for those who will surely die. Caregivers wonder whether the effort is worthwhile. So long as care is medically indicated, that is, it offers hope of prolonging meaningful life, improving the patient's condition, making the patient more comfortable or reducing the patient's suffering, it is worthwhile. Questions of cost and responsibility for payment should be discussed by policymakers but should not influence the physician's care for the individual patient.

It is permissible to limit care for the terminally ill under two conditions: first, when the patient has refused to consent to treatment and, second, when treatment is not medically indicated. Refusal of treatment may be given by the patient. Indeed it is wise to discuss as early as possible with the patient the treatment the patient wants and wants to avoid. Such discussion maximizes the autonomy of the patient. Patients can express these views through living wills or orally. They can also designate another to decide for them when they are not capable of doing so. The durable power of attorney is useful for this purpose. The durable power of attorney is especially useful in the case of homosexual lovers where the partner will have no legal standing, but may be the individual who knows most about the patient and the patient's wishes. Often these grieving partners are rejected by family members and can play no role during a patient's final days.

If a patient is no longer capable of making decisions about treatment and has neither a living will nor a durable power of attorney the patient's wishes should still be respected. This is referred to as the substituted judgment standard. The doctor should

attempt to determine what the patient would have wanted. The patient may have discussed such issues with the doctor, with friends, or with family members. If the patient's attitude toward treatment can be determined that attitude should be followed.

If it is not possible to know what the patient would have wanted, the best interests standard should be followed. What is in the patient's best interest? This is really like asking, "What is medically indicated? Will the patient benefit?" If there is no benefit to the patient a treatment should not be undertaken.

CPR can be such a treatment. Given the risk of injury, and the poor prognosis for mental functioning of many who are resuscitated, deciding not to resuscitate can often be an appropriate decision. Such an order must be written into the record. Informal "slow codes" or "purple dots" are not acceptable. They are devices to avoid responsibility for decisions and unfairly burden other caregivers such as nurses. Other treatments such as antibiotic therapy may also be withheld when appropriate.

Sometimes caregivers feel that once a procedure is begun it cannot be withdrawn. Although there may seem to be an emotional difference, from an ethical perspective they are the same. One need not continue to treat if there is no medical reason to do so. One should not fail to initiate a treatment because one fears to discontinue it later. If it is tried and no longer helps, it can be stopped.

8. *May a physician assist an AIDS patient in suicide?*

Depression may well accompany HIV infection. Patients may decide to commit suicide and may seek a physician's help in doing so quickly and painlessly. The physician may feel that in similar circumstances he/she would undertake the same act. Nonetheless the physician cannot justifiably assist suicide either on moral or legal grounds. The doctor's obligation is to assist the patient toward life. This may require counseling, it may require referral to a therapist or counselor, it may require contacting a clergyman or family member for help, or it may require finding help for the patient in getting social services. If the patient's request is done in order to avoid pain the physician should assure the patient that he/she will do what is necessary to keep the patient pain free and fulfill that promise.

9. *How can a doctor remain compassionate toward HIV infected patients?*

Caring for AIDS patients can be taxing. The section on obligation to treat lists the reasons doctors may find it difficult to care for them. The rewards may seem fewer and the demands greater. If a physician takes care of very many such patients he/she may become tired. If the doctor tries to meet the emotional needs of these patients his/her own emotions may be drained. Maintaining the ability to be compassionate may be much harder than maintaining the ability to deliver technically competent treatment.

But the need for compassion is great. The tragedy of the disease and its terminal character cry out for human concern. Who better than the physician can see the meaning of this terrible disease process? Who better to express understanding and support for the patient? The doctor who sees the physician role as primarily one of curing may find it difficult to feel successful caring for the AIDS patient. The doctor who sees other aspects to the physician role may find it easier. Doctors have provided comfort and eased pain for as long as medicine has existed. Curing is a recent phenomenon; caring has always been central to what doctors do. Recalling that tradition may be helpful at this time.

Doctors should also take good care of themselves. If one sacrifices too much of oneself today one will have nothing to give tomorrow. Physicians facing the emotional demands of caring for AIDS patients should take time to seek the support of others. Other physicians should offer their support. Talking out frustrations can help. Doing all those things doctors tell patients to do to reduce stress can help doctors as well. Above all recognizing the value to patients of the care one gives can provide rewards even though the patient ultimately dies. Physicians should recall the words of the 18th century physician John Gregory. "It is as much the business of the physician to alleviate pain and smooth the avenues of death, when unavoidable, as to cure diseases."

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SPECIAL ARTICLE

Analysis of Florida Data on Malpractice Insurance and Litigation in Orthopedic Surgery

Ray Bellamy, M.D., and Arthur Pearl, M.D.

INTRODUCTION: There were 279 respondents (approximately 40% return) to a survey of Florida orthopedic surgeons regarding malpractice litigation/insurance experience. Over 72% of those practicing more than five years have been sued at least once. Suits are more frequent in south Florida, averaging 1.5 suits/surgeon compared with 1.3 suits/surgeon statewide, and insurance coverage is more expensive, averaging $57,382 in 1988 compared with $51,097 statewide. In south Florida, 22% of the respondents reported no liability insurance coverage for 1988 compared with 14% statewide. Asset protection steps have been taken by 56% of Florida respondents and by 70% of those from south Florida. Seventy percent of respondents have limited their practice in some way, most commonly by reducing emergency room coverage or discontinuing spine surgery.

Over 50% of patients who became malpractice litigants originated in the emergency room but lawsuits usually arose because of alleged injury in the operating room. Judgment or settlement averaged $61,221 per case filed and took an average of 3½ years to conclude. Ninety percent of the incidents resulting in suit were judged by the surgeon to be adverse results rather than the result of negligence.

Based on this study, the premiums paid in a single year (1987) nearly equaled the total amount of money paid out to plaintiffs (and their attorneys) in all the years of practice (average 15 years) of the respondents.

The fact that over 72% of the respondents in practice over five years have been sued at least once would tend to negate the argument that "a few bad doctors are causing the problem".

The problem of malpractice insurance costs and reasonable tort reform is compounded by rumor, half-truths, rhetoric, and a scarcity of facts. Traditionally, physicians have been reluctant to mention the "M word" for fear of arousing suspicion among their peers and the public and encouraging patients to sue by suggestion. However, when enough of our peers face litigation and individual physicians must make practice decisions based on hearsay and very little concrete information, an effort to obtain factual information on this subject becomes a necessity.

In spite of the efforts of the February legislative session in Florida to deal with this problem, no one expects the medical malpractice insurance crisis to be solved by its activities.

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Survey • In November 1987 Florida Orthopedic Society Legislative Chairman Arthur Pearl, M.D., of Miami, authorized a survey among Florida orthopedic surgeons of the general subject of malpractice. The survey was to be loosely patterned after the recently-published Florida Neurosurgical Society survey. We decided to modify the neurosurgical survey format somewhat in order to obtain data on the number of orthopedic colleagues choosing to practice without liability insurance, and to survey all orthopedic surgeons in Florida, not just society members. The questionnaire was mailed out to the membership in mid-January 1988 and some 230 responses were received within the first two weeks. Some respondents

took the time to write detailed letters of explanation or suggestion, and the answers to the open-ended question, "Is there anything additional you would like to say on the general subject of malpractice and the liability crisis in Florida?" were nothing short of amazing. What follows is our attempt to assimilate rapidly the information gleaned from the survey and to suggest the meaning and implications of the results.

Meaning and implications of results ●

1. There were 279 respondents to the survey which was mailed to approximately 825 orthopedic surgeons in Florida, including 63 residents, additional academic faculty and some retired orthopedists. Counting only orthopedic surgeons in private practice, the response rate is estimated to be about 40%.

2. Responses by region

Panhandle	15
North	39
Central	87
South	121
Unspecified	17

3. Years in practice of respondents

0-5	41
5-10	61
10-20	103
20-25	25
25-30	16
Over 30	16

Average 15 years

4. Number of suits: 331 reported by 259 respondents

By region

Panhandle	Average 0.86 suits per surgeon
North	Average 0.92 suits per surgeon
Central	Average 1.16 suits per surgeon
South	Average 1.52 suits per surgeon

By years in practice

0-5	0.5 suits/surgeon average
5-10	0.88 suits/surgeon average
10-20	1.65 suits/surgeon average
20-25	2.04 suits/surgeon average
25-30	1.27 suits/surgeon average
Over 30	1.19 suits/surgeon average

Of orthopedic surgeons in practice more than five years 72% have been sued at least once. There have been an average of 1.3 suits/surgeon statewide.

By bare physicians

There were an average of 1.7 suits/surgeon for those reporting no liability insurance coverage for 1988.

5. Insurance coverage limits for 1987 for respondents averaged $629,000/$1,622,000. This includes "bare" physicians and those with limited immunity through the Veterans Administration and university systems.

6. Total amount of money paid out in liability insurance premiums in 1987 by the respondents to this survey was $11,673,200. This includes some orthopedic surgeons who obtained coverage for non-surgical practices, "bare" physicians without insurance, and so forth.

7. Insurance coverage limits for 1988 averaged $521,000 and $1,324,000. This figure also includes those with limited immunity as employees of the state university system and VAH and a greater number of orthopedic surgeons with no professional liability insurance coverage.

8. Cost of insurance in 1988 averaged $43,700. As in #6, this figure includes 33 "bare" physicians (14% statewide) and those who reduced their premium by various maneuvers such as dropping the "tail" coverage and obtaining entry-level coverage at first year claims-made rates with a new company, as well as those who have discontinued surgery, those who assist in surgery only, etc.

For those <u>with</u> insurance, the cost averaged $51,097 statewide.

For those with insurance, cost averaged $48,343 in North Florida, $48,133 in the Panhandle, $46,303 in Central Florida, and $57,382 with 22% bare in South Florida.

9. Asset protection steps had been taken by 56% of the respondents statewide; 70% of those practicing in South Florida. This includes assets placed in joint ownership, spouses name, various trusts, annuities, etc.

10. Limitations on practice as a result of the liability situation were declared by 70% of the respondents. Twenty percent had limited ER calls either completely or reduced ER exposure; 8% were no longer operating; 22% were not operating on spine problems or treating cervical spine injuries, and 7% were not doing any complicated children's surgery. Other methods of practice limitation mentioned by respondents were: not handling "litigious patients", not treating lawyers or their families, not taking calls in charity hospital ER situations, and otherwise avoiding cases felt to be "high risk". More frequent consultations, tests, and referrals were frequently mentioned.

11. Comments on "going bare" and effect on mental state ranged from strongly negative to strongly positive. Some described the effect as "awful" or "terrifying", "very stressful". Others declared they would cancel their professional liability insurance immediately if only their hospital allowed them to do so, and some suggested the ultimate solution to the liability insurance problem would only be for all of us to go "bare".

12. Lawsuit incident summary

A. Age of plaintiffs range from newborn to 78 years with an average of 39 years.
B. Origin of patient — 51.5% of the plaintiffs began their treatment relationship with the orthopedic surgeon in the emergency room.
C. Type payment for care
46% Private or other insurance
23% Workmen's Compensation
15% Indigent
9% Medicare
2.5% Medicaid
1.6% CHAMPUS
1% Children's Medical Services
<1% Elks
<1% Federal prison
D. Location of alleged injury
52% Operating room
18% Hospital environment
16% Office
13% Emergency room
E. Outcome
36% Settled for monetary amount
28% Dropped
25% Pending
9% Won
3% Lost
F. Amount of settlement or judgment
$61,221 average per case file
$272,000 average in Panhandle Region*
$26,014 average in North Region
$21,575 average in Central Region
$90,561 average in South Florida
Settlements averaged $190,634
Judgments averaged $529,500

Amount of money paid out to plaintiffs and their attorneys in all the years of practice of the respondents to this survey (average 15 years) totaled $13,520,700.

G. Years to completion of settlement or trial.
The average time to completion of trial or settlement was 3½ years.
H. Reported to carrier prior to notification?
Of incidents resulting in lawsuit reported here 65% were not reported to the insurance carrier prior to notification of the suit.

13. Plaintiff attorneys filing suit against orthopedic surgeons.

There were many plaintiff attorneys filing one suit against a Florida orthopedic surgeon but only a few were mentioned more than once in this survey. Those mentioned filing three or more suits were:

Sams and Ward - Miami - 7 suits
Rosenblatt - Miami - 5 suits
Roberts - West Palm Beach - 5 suits
Fixel - Ft. Lauderdale - 4 suits
Cunningham - Tampa - 4 suits
Schlesinger - Ft. Lauderdale - 3 suits
Lagrone - Orlando - 3 suits

14. Defense attorneys

Malpractice defense was handled by a number of different law firms around the state with no predominate firm evident.

15. Plaintiff witness

Forty percent of expert witnesses for plaintiffs were from out-of-state. Those listed as in-state on more than two occasions were:

Weiner - Hollywood - 10 times
Gardner - Ft. Myers - 5 times
Gordon - Deerfield Beach - 3 times

16. Negligence vs Adverse Result

Ninety percent of incidents resulting in suit were judged by the orthopedic surgeon defendant as an adverse result rather than negligence. In some instances, the incident was felt to be neither, such as "part of the natural history of the underlying disease". In some instances, the suit was felt to have been filed for fraudulent reasons, such as "missed carpal navicular fracture" when the roentgenogram demonstrated an old nonunion. In many instances, the assistant surgeon for an operation resulting in suit was named along with the primary surgeon when there was little evident reason to suspect negligence on the part of the assistant.

17. Medical cause of the lawsuit

Malunion of fracture, nerve injury, postoperative infection, vascular injury, compartment syndrome, reflex sympathetic dystrophy, broken internal fixation device, operation on wrong extremity, and misdiagnosis were among the many allegations made by plaintiffs. There was no predominate procedure or pattern identified, except that most often suit resulted from operative — or trauma-related actively.

*There were only two reported settlements and judgments in the Panhandle in this survey. The awards were for $1 million and for $360,000.

18. Claims experience for those paying $100,000 or more for malpractice insurance in 1988

All four orthopedic surgeons who reported paying $100,000 or more in 1988 liability premiums were from south Florida. One who had been practicing between ten and 20 years with no reported suits filed is paying $125,000 for $1 million/$3 million coverage.

One physician practicing between five and ten years in Florida is paying $120,000 for $1.5/$4.5 million coverage. This physician reported one suit with a judgment of $90,000 for arthroscopy on the wrong knee.

Another physician reports paying $160,000 for $500,000/$1 million coverage. This orthopedic surgeon has been in practice between ten and 20 years in Florida and reports one suit pending and no other suits.

Another physician reports paying $153,000 for $1/$3 million coverage who has been in practice between ten and 20 years with five suits filed. But two of those were dropped and one suit for malunion of the radius was settled for $13,000. Status of the other two suits was not reported.

19. Cost of insurance

The cost for those reporting more than three claims was apparently about 30% higher than those with fewer claims. The average cost for 1988 premium for these surgeons was $48,000. Three of these orthopedists were without coverage. For those with coverage, the premium averaged $68,571, compared to a statewide average of $51,097.

20. Comments

Many respondents had comments regarding the liability situation in Florida. Some were classified as derogatory, some as suggestions for solving the crisis, and some observations or declarations to take individual action. We intend to publish those comments in the Florida Orthopedic Journal along with a compilation of procedures resulting in suit. The responses were fascinating and reflect a high level of disgust and frustration with the problem. The impression one gets from these responses in the aggregate is that of a large pool of confirmed enemies of the legal community, most have little faith in the ability of the legislature to solve this crisis.

21. Additional information provided by the survey

One orthopedic surgeon reported being served with a lawsuit on the steps of his home on Christmas morning in front of his wife and children, apparently as an attempt at intimidation. Another reported settling a case thought to be defensible at the advice of his insurance carrier and then having his coverage canceled. Lawsuits were reported against orthopedic surgeons as a result of their peer review activities in limiting hospital privileges of a podiatrist in one case and as a part of hospital peer review activities in a different instance. One suit was settled when the defense attorney was threatened by the plaintiff with a gun. In another instance, the orthopedic surgeon who had assisted in an operation was added to the suit 2½ years after filing against the primary surgeon "in order to decrease my credibility as a defense witness". In an unusual instance, the orthopedic surgeon was sued for "conspiracy to deprive plaintiff of Workmen's Compensation Benefits". The malpractice carrier refused to cover legal expenses incurred by the defendant surgeon. Some generalizations are possible from the responses gathered in this survey.

A. Mood

Florida orthopedic surgeons are frustrated with their legal encounters and with the cost of liability insurance. The tort system is seen by most as unfair to physicians and plaintiffs, extremely costly, slow, and almost intolerable.

The combination of shockingly poor quality encounters with the legal system in some instances and the fact that most orthopedic surgeons have been sued has clearly poisoned the professional relationship between physicians and attorneys. One suspects that attempts by some inexperienced and overzealous attorneys to intimidate the physician defendant and force an out-of-court settlement may be behind some of these actions and their inevitable sequelae. Regardless of etiology, it seems that each medicolegal encounter which is perceived by the physician as patently unfair leaves another lifelong enemy of the tort system in its wake. Given the increasingly frequent interfacing of the two groups, it is not surprising that an enlarging group of confirmed enemies of the plaintiff bar and to some lesser degree the legal system in general has developed. Unfortunately, attempts have so far come to naught to attain reasonable compromise between the medical and legal communities on these issues which chafe regularly at the medical delivery system.

B. Individual actions

Ultimately, each individual physician must look at his or her particular situation and make choices compatible with the practice environment at that time. Some hospitals will not allow physicians to be on staff without carrying a specified amount of insurance coverage. Switching hospitals to one not requiring insurance may not be an option.

Dropping coverage by one company and purchasing first year coverage from another without tail coverage may satisfy some hospital and HMO requirements and avoid the requirement to notify the public of insurance nonavailability while significantly reducing insurance purchase cost. This ploy could be interpreted as, at best, marginally complying with the

intent of the law since many suits are not filed within the first year of the incident. It is clear from figures regarding the frequency with which an incident resulting in suit is reported to the insurance carrier in advance of the notice of suit that many suits are not anticipated.

For others, early retirement, discontinuing surgery, leaving private practice, or leaving Florida are viable solutions. Many respondents, some who had been in orthopedic practice in Florida only a few years, declared their desire, but inability, to quit orthopedic practice.

"Going bare" is apparently a valuable alternative for many and is the preferred method for the authors of this report. Many respondents felt the liability crisis would quickly disappear if all Florida orthopedic surgeons went without insurance coverage. Although a hospital may disallow individual physicians from going without liability insurance coverage, when large numbers of their physician staff "go bare" it is difficult for the hospital not to allow such action or, alternately, to make arrangement to share in the cost of insurance premiums.

Another category of individual action is aimed at reducing the risk of a lawsuit rather than reducing the cost of insurance. This may mean discontinuing emergency room coverage, or, as 70% of the respondents have done, limiting one's practice in many ways to reduce risk. Reducing emergency room coverage is obviously effective in reducing risk of suit, since for the respondents in this survey, over half the lawsuits developed following treatment of patients encountered in the emergency room. The recent legislation aimed at protecting physicians in emergency situations presumably will not help reduce this risk in orthopedic surgery, since most of the suits occur as a result of subsequent operating room (52%) and hospital (18%) treatment after the patient leaves the emergency room.

Several physicians reported greater utilization of second opinions, referrals, and tests. Some estimates are that 40% of the testing done in medicine represents defensive medicine and is not requested for the benefit of the patient.

C. Insurance benefits to injured parties

The total amount paid out in liability insurance premiums in 1987 by respondents to the survey is $11,673,200. The total amount paid out to plaintiffs (and, of course, shared with their attorneys) in all the years of practice (average 15 years) for the orthopedic surgeons responding is not much more than one year premium collections, $13,520,700. There are, of course, claims pending now, and there will be some other suits during the course of the year (presumably this insurance is all claims-made in type) but the conclusion is inescapable that very little of our premium goes to compensate injured patients.

D. Suggestions for the future

It is difficult not to become discouraged about the prospects for meaningful change in the professional liability environment in Florida. The modified MIRA Bill, which was opposed by the Florida Orthopedic Society prior to its weakening in the special session, faces almost certain constitutional challenge. Whether it will significantly affect liability insurance rates or the percentage of the premium dollar which ultimately finds its way to plaintiffs is very questionable. Certainly, as mentioned in B, the altered definition of negligence in emergency situations does little to reduce the liability for orthopedic surgeons who take emergency calls.

The vast majority of suits seem to be filed by personal injury attorneys who apparently handle few medical malpractice suits and may not be prepared to judge the merits of a case. There is some evidence that law firms experienced in this area take on only clear-cut cases and may do a better job of screening out nonmeritorious claims. But with the plethora of personal injury attorneys vying for clients and a pool of generally angry, dissatisfied and medically underinsured former patients, it seems inevitable that many of these plaintiffs will eventually connect with an attorney who will initiate suit. Legislation designed to discourage frivolous suits may not prevent this, since the burden for payment of defense costs is placed on the plaintiff in such instances, but the plaintiff, apparently, in most such instances is adjudged unable financially to shoulder the payment of defense costs, thus risks nothing. Perhaps making the plaintiff attorney responsible for reimbursing defense costs in such instances might help solve this difficulty.

The effort to cap noneconomic damages at $100,000 might make a significant difference in premium rates. An additional effort might be directed at significantly limiting attorney contingency fees for all torts, not just medical liability.

Dr. Alfred Swanson of Grand Rapids, Michigan, tried twice to get a constitutional amendment on the ballot in his state to limit attorney contingency fees. His proposal would limit the attorney fee to 33% of any award up to $200,000 and 5% of any amount above $200,000 in all tort cases. Such an amendment might enjoy widespread nonmedical support, and, in combination with a $100,000 cap on noneconomic damages, might be expected to make a real impact on the liability situation.

Our hope is that this information may prove useful to those who are wrestling with the personal decisions necessitated by the liability crisis and may help stimulate efforts to attain meaningful long-term resolution.

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Quantitating Quality in Medical Practice:

An Economic Reality or Another Mythic Voyage in Pursuit of the Golden Fleece?

Fortunately, health policymakers have recently recognized that containment of medical care costs, dissociated from concerns for the quality of medical care, is an exercise in economic delusion. The scattered debris from the Medicare-HMO and Medicaid experiences has demonstrated that the long-term expenses from neglected disease or low-budget medical care exceeds, by far, the savings in short-term dollar expenditures that these programs fostered.

Shortell and Hughes in the April 28 New England Journal of Medicine add statistical validity to the contention of physicians that the firestorm of cost containment measures that have blown over this nation during the last five to ten years may be having adverse effects on the nation's health. This article reported that death rates for 16 common medical conditions were 6-10% higher in those states that had stringent hospital rate review laws and 5-6% higher in states with severe certificate of need legislation when compared with states without such restrictive regulation.

These concerns about quality are admirable. Even the Health Care Financing Administration (HCFA) pays lip-service to the importance of quality. It attempts to monitor quality of care to hospitalized patients through the peer review organizations (PROs) which, allegedly, assure that hospitalized Medicare patients receive a brand of care that measures up to certain standards. In reality, the PROs are not examining quality; they are measuring the process of the medical care being rendered and not the outcome. Furthermore the HCFA efforts cannot quantitate the broad spectrum of care that is given. It can identify and punish the severely defective providers and eject them from the Medicare provider system; it cannot rate, on any type of evaluative scale, the broad spectrum of quality of services given by hospitals, doctors, or other providers with its current procedures.

In December 1987 HCFA released its information on mortality rates for the 6,000 hospitals that provide care for Medicare patients. The report was immediately assailed for all its inherent weaknesses. It failed to account for the differences in case-mixes among the different hospitals, i.e., it failed to account for the fact that an inner city hospital that took care of severely traumatized patients because of the presence of a trauma center would be expected to have a higher case mortality ratio than would a suburban hospital that did not care for trauma patients. The report also failed to account for differences in the severity of patients' illnesses that exist among hospitals. The study attributed all deaths that occurred within 30 days of a hospital admission as hospital related but did not have any means of determining whether a death was related to the hospitalization or not. Despite the lack of quality of HCFA's report on quality, William Roper, M.D., defended the report with the contention that imperfect information is better than no information. Furthermore HCFA plans to continue to release its annual hospital mortality rate report and it will publish other reports on quality about physicians, HMOs, and nursing homes in the future.

Physicians, of course, welcome the concern with quality in the cost compression milieu in which we operate. As demonstrated by the hospital experiences with HCFA, we need to be deeply concerned about the legitimacy of the yardsticks used to measure quality.

Physicians have always been concerned with their own quality of medical care and that of their colleagues. If a group of doctors on a hospital staff are asked to rate their peers with some numerical scale they can do so and with surprising agreement in most cases.

Measuring quality ● What are the criteria we use to measure quality of medical care and of the doctors who deliver it? We place much emphasis on the doctor's wealth of knowledge and manner in which he translates that knowledge into clinical judgment in using diagnostic and therapeutic procedures. We evaluate the clarity of mind reflected in his or her chart notes or the opinions given at hospital or departmental meetings. We evaluate his or her performance based on the opinions of colleagues and patient feedback. We look at the service aspect the doctor gives to both his patients and to ourselves as potentially referring doctors. The doctor's demeanor, dress and speech also influence us. Most of these criteria, however, are soft. They are not quantifiable. It is

similar to being a member of an avant-garde artistic group. When Picasso and Georges Braque were experimenting with the rudiments of cubism in 1907-1910, their colleagues and closely associated painters recognized the value of their work instantly; but it took several decades before others could appreciate the creativity and artistic splendor of what they had done. In many instances, our measurements of the quality of medical care are as arcane and as subjective. Subjectivity is inadequate for the 1990s.

If quality of medical care is to be quantitated it must first be defined. The major difficulty confronting health care policymakers and scholars is that no one knows how to define quality of care. Until now people have focused on the process of care, i.e., examining patients charts, video recording the interview between doctor and patient, measuring the time spent by the doctor with the patient. Some people would like to define quality of care by observing the *output* of the care. For instance, did the result of the patient's care lead to a cost-efficient diagnosis, cure, abatement of painful symptoms or anxiety, improvement in the patient's quality of life or in the attainment of additional functional capability? These are but a few of the outcome parameters that could be measured. The difficulty is that years may expire before the final outcome of a given therapeutic procedure or treatment regimen can be determined. This delayed determination makes outcome parameters far from ideal measures of quality. Great expense will also be involved in measuring outcomes of care in a prospective fashion.

The second means of measuring quality is to set standards of care and determine if those standards are fulfilled. This assures that some minimum level of care has been conducted. It does not give any estimate of the gradations of good care that satisfy and supercede the minimal standards. The major difficulty, though, of standards is that their establishment will be very difficult. Policymakers recognize that much of what doctors do is unsupported by data about the efficacy and cost effectiveness of the procedures performed. For instance, data do not exist that demonstrate that cholecystectomy for asymptomatic gallstones extends a patient's life. Eddy and Billings have pointed out how difficult it is to measure the efficacy or utility of many surgical procedures and use the example of a single surgical procedure — percutaneous transluminal angioplasty; they show how difficult it is to compare the utility and outcome of this operation with that of an alternate procedure, bypass surgery.

Measuring value ● We have trouble justifying some of the diagnostic testing that we do. For instance, many physicians proclaim that every person over 50 should have an annual test for fecal occult blood and a flexible sigmoidoscopy performed. Some experts believe this diagnostic regimen would almost eliminate the risk of death from colonic cancer; others that it would be virtually useless. Since 62 million people fall into this age group the cost of pursuing the policy is significant. Nobody has ever studied the outcomes of such a regimen on a large enough population to test its validity. Thus, there are no data to guide people who make standards of practice and there is no consensus among the experts as to the value of the procedure. Similarly, the value of magnetic resonance imaging for many diagnostic procedures cannot be weighed because studies that evaluate its economic and diagnostic merit and compare it to other, cheaper procedures, do not exist in most instances. If the information about the appropriateness of a procedure — either therapeutic or diagnostic — is nonexistent, how can standards for quality of care be adapted?

How do we, as physicians, accept the utility of a procedure if data proclaiming its efficacy are so deficient? We operate on the principle of potential benefit, i.e., if a procedure might help the patient while not doing significant harm, then we accept is as appropriate. This concept can be harmful in many ways. This principle does not allow us to choose wisely between two or more alternative procedures; hard data are required for that decision. Operating under the principle of potential benefit excuses us from searching for scientific verification of the procedure and thereby permits us to overestimate the benefits and, perhaps, underestimate the risks. This principle stimulates us to drive up costs by attempting to do everything that might be potentially beneficial for our patients; payors, therefore, may be buying services that may have no benefit. If resources are limited, operating under this principle prohibits us from prioritizing the allocation of those resources. Finally, working under the guidance of this principle self-deludes — it makes us overestimate our knowledge base when we are really ignorant.

Drug therapy is not crippled by the same ignorance that encompasses so much of the remainder of the diagnostic and therapeutic operations used in medical care. Changes forced upon the drug industry two decades ago have assured that new medications have well defined zones of efficacy and risk established for them before their acceptance into general practice.

Establishing standards ● The fog of uncertainty that gauzes over the scientific worth of much of the remainder of doctors' activities makes the establishment of standards of practice most difficult. Policymakers no longer will accept the opinion of a panel of experts; they are critically demanding hard numbers from us to support our opinions.

Thus dependence upon outcome measurement and upon the establishment of standards of care will not assure quality of care and will give policymakers no insights into the ranges of excellence of care that exist in medical society. While awaiting data that assess the efficacy, cost efficiency, safety, and outcomes

produced by our activities, the truly conscientious and excellent doctor who practices in a cost effective fashion will continue to be penalized.

Are there no currently available methods that can measure quality of care? Sophisticated computer software programs exist that measure quality of care in the hospitalized patient. The programs are not yet applicable to the outpatient setting. HCFA and others have proposed that quality of care be assessed by asking the consumer about his or her satisfaction with the medical care given. Consumer opinion about the excellence of care is an area that most doctors have rejected as invalid. Consumers are interested in the humane more than the scientific aspects of medical care. The politeness of the staff and the physician, the cleanliness of the office and its general appearance are thought to bear more heavily on consumer assessment of quality of care than does the training, decision-making abilities, and procedural skills of the doctors. However survey techniques that measure consumer opinion are being developed and tested and most of us will be subjected to such surveys during the next two to four years. HCFA is also accumulating data about readmission rates to hospitals as a method of measuring the value of previous hospitalizations. Insurors have sponsored the development of statistical packages that estimate quality of care from the diagnostic and procedural code data that are submitted to them. Some scholars believe that this technology is significantly advanced to apply to the quality estimation problem.

Medicine is a profession. Our society has allowed professions to function in an independent fashion, to establish methods of payment for themselves and to monitor and discipline its members. Professionals resent monitoring by outsiders; doctors are no different. Unfortunately, we have become so successful in what we do and have commanded so much of the gross national product that we are losing our professional prerogatives. We are no longer permitted to practice in a sacristy that is shut out to inspection by others and by rituals that are blindly accepted and unchallenged by outsiders. We doctors understand the technology of the quality of care issue. It will be advantageous to us to interact with the policymakers and to honestly and cooperatively interpret the technical facets of the quality issues that will be thrust upon us. We must admit the limitations of our knowledge and be willing to subject our practices to the scientific and economic scrutinies that are deserved. Doctors, not policymakers, must insist that the questions of quality, efficacy, safety and economic efficiency are implemented by doctors and not by outsiders. We will be allowed this rite of professionalism only if we cooperate and lead the quest for information about quality that the profession sorely needs.

Bibliography

1. Blumberg MS.. Measuring Surgical Quality in Maryland: a Model, Health Affairs, Spring 1988: 62-78
2. Caper, P.: Defining Quality in Medical Care, Health Affairs, Spring 1988: 49-61.
3. Eddy, D.M. and Billings, J.: Quality of Medical Evidence, Health Affairs, Spring 1988. 19-32.
4. Iglehart, J.K.: Competition and Pursuity of Quality: Conversation with Walter McClure, Health Affairs, Spring 1988. 79-90.
5. Lohr, K.N.; Yordy, K.D., and Thier, S.O.: Current Issues in Quality of Care, Health Affairs, Spring 1988: 5-18.
6. Roper, W.L. and Hackbarth, G.M.: HCFA's Agenda for Promoting High Quality Care, Health Affairs, Spring 1988: 91-98
7. Shortell, S.M. and Hughes, E.F.X. Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients, NEJM 318:1100-1107, 1988.
8. Wennberg, J.E.: Improving the Medical Decision Making Process, Health Affairs, Spring 1988: 99-106.

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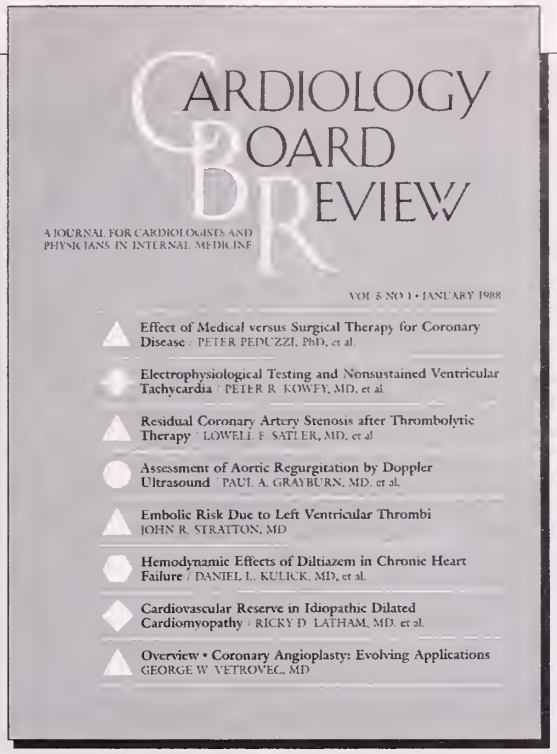

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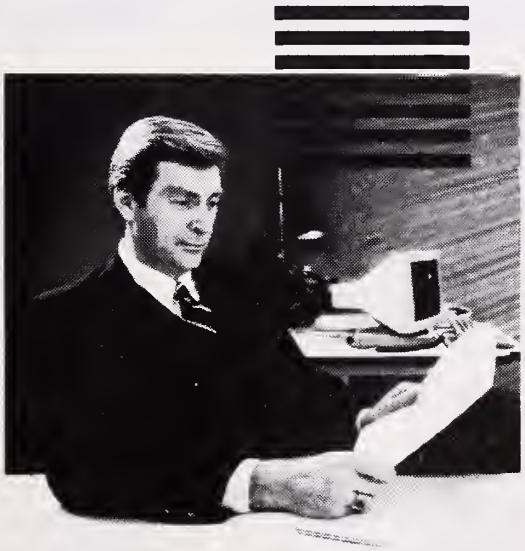

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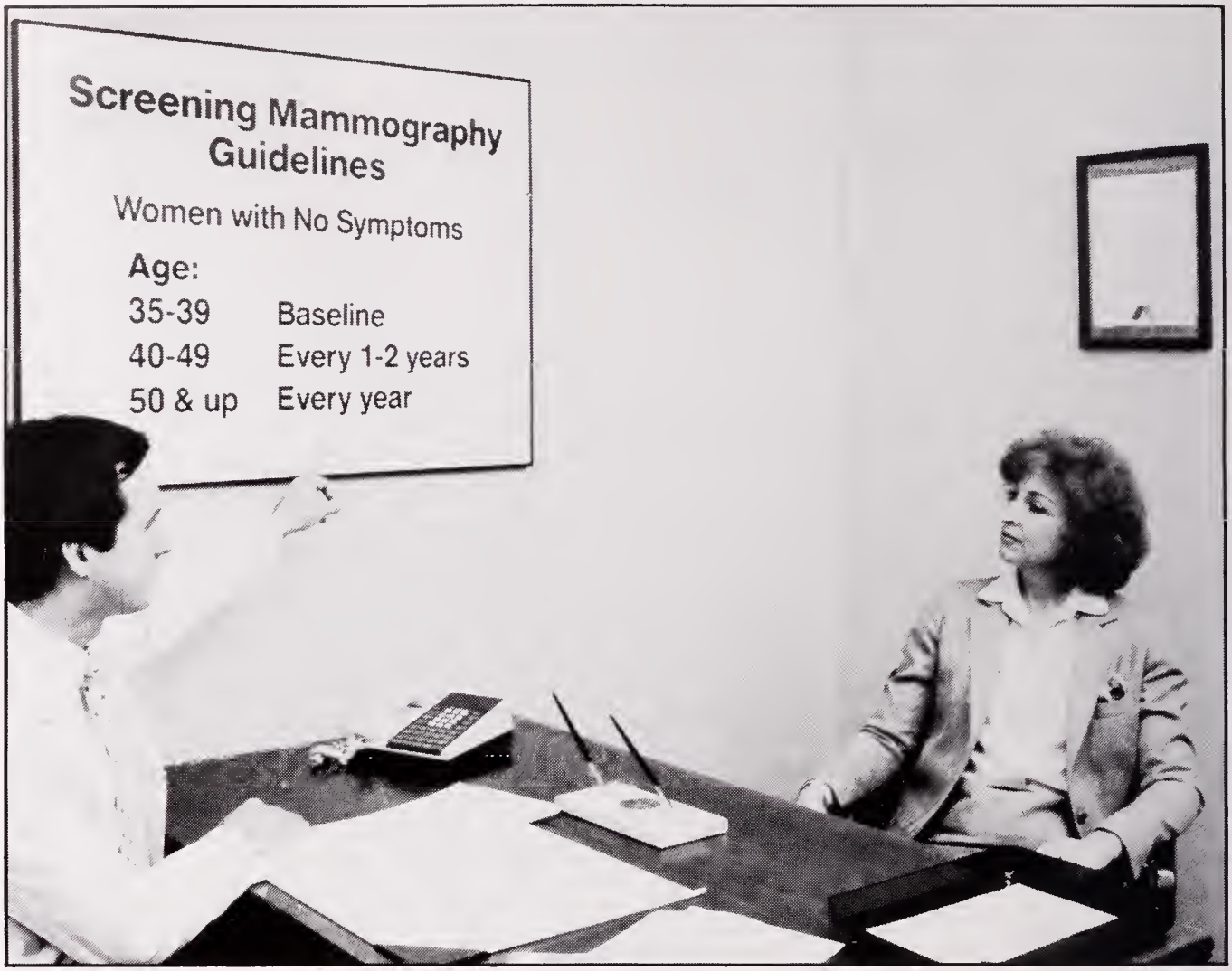

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†See Warnings and Precautions.

Please see brief summary of prescribing information on the next page.

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diltiazem HCl/Marion

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(diltiazem HCl)

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BRIEF SUMMARY
Professional Use Information
CARDIZEM®
(diltiazem HCl)
30 mg, 60 mg, 90 mg, and 120 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), and (4) patients who have demonstrated hypersensitivity to the drug.

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.)

Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a one-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/ postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree—see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, depression, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGDT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, CPK elevation, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 6/87

See complete Professional Use Information before prescribing

References: **1.** Schroeder JS: Mod Med 1982;50(Sept):94-116. **2.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease. A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, W B Saunders Co, 1984, chap 39. **3.** O'Rourke RA: Am J Cardiol 1985;56:34H-40H. **4.** McColl D, Walsh RA, Frohlich ED, et al: Curr Probl Cardiol 1985;10(8):6-80. **5.** Frishman WH, Charlop S, Goldberger J, et al: Am J Cardiol 1985;56:41H-46H. **6.** Shapiro W: Consultant 1984;24(Dec):150-159. **7.** O'Haro MJ, Khurmi NS, Bowles MJ, et al: Am J Cardiol 1984;54:477-481. **8.** Strauss WE, McIntyre KM, Ponsi AF, et al: Am J Cardiol 1982;49:560-566. **9.** Feldman RL, Pepine CJ, Whittle J, et al: Am J Cardiol 1982;49:554-559.

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Don't Allow Greed to Wreck America's Tort/Insurance System

All it takes to solve the litigation crisis is the political will to overcome the economic self-interest of lawyers.

The high cost of litigation has created a shakedown racket. For example, if an innocent company knows it will cost $50,000 to prove it doesn't owe the plaintiff a nickel, it makes economic sense to settle for $5,000 or $10,000. This fact has encouraged many people, including some lawyers, to view litigation as a form of lottery or even legalized blackmail.

To restore the tort system to its normal state, we need only:

- Cap contingency fees, by law, at 7 percent.
- Require losers in a civil action to pay the legal fees of the winner.
- Eliminate or cap at no more than $100,000 compensation for "pain and suffering."
- End doctrine of joint and several liability (more accurately called doctrine of deepest pocket).
- Repeal the 30 or so federal laws that authorize the payment by the taxpayers of attorney's fees in so-called public-interest cases.
- Hold lawyers to the same standard of truth in advertising and contracting as other businesses by making them explain to potential clients that in contingency-fee cases the clients are responsible for all expenses if they lose, and require lawyers to provide the client with a written estimate of those expenses.

Those steps would restore the system to where it was before greed ripped it apart. It would provide a reasonable remedy to people negligently or maliciously injured, but it would give no incentive for the greedy to get rich at the expense of the rest of us.

There is no free lunch. If you just think of most transactions as a transfer of money, then you can easily realize that if one plaintiff collects $1 million, that $1 million has to come out of somebody else's pockets. Those pockets are the public's because the money comes out in the form of higher insurance premiums and higher prices for goods and services.

Contingency fees that now run from a third to half of recovery are simply an incentive to turn the courts into a lottery system. I don't know of any other country that allows them to be this high.

Pain and suffering is just a come-on for greed. If I break your arm, we can determine exactly how much it costs to restore your arm and to compensate you for time off the job. How can we qualify the pain? How can we qualify grief? What's grief worth? $100,000? $10 million? There is no rational way to translate subjective feelings into cold cash. We can sympathize with suffering, but we should not reward it. Most especially, we should not reward the plaintiff's lawyer for the plaintiff's suffering.

The deep-pocket doctrine means that if someone with no money is 99 percent responsible for the injury but someone with money is 1 percent responsible, then the 1 percenter pays the whole bill. This is unjust, and it encourages lawyers to shop for suits that may involve, however remotely, a deep pocket.

The tort system was never designed to be a substitute for God and to make our lives peachy-creamy. Sometimes we suffer a loss through our own negligence or carelessness. Sometimes we suffer a loss through the negligence of somebody who is broke. It may not be just but it's life.

There has grown among some people the belief that life is supposed to be perfect, that if anything goes wrong, from mild inconvenience to disaster, then somebody should pay compensation. That may be a side effect of dumping religion and philosophy and substituting sociology, ideology and psychology. It's as far from reality as belief in the Easter bunny.

The tort/insurance system is a sound and necessary one for a civilized society, and we ought not to allow personal greed to wreck it. It's malfunctioning now. We can either fix it or lose it.

Charley Reese

Reprinted with permission from The Orlando Sentinel, Monday, April 25, 1988.

Mr. Reese is a staff writer for the Orlando Sentinel.

The Cannibalism Must Stop

The frustration of physicians with their apparent impotence in resolving threats to their standards and methods of traditional private practice has frequently resulted in a misdirection of their energies towards ultimately self-destructive behavior.

Medical societies, whether county, state, or national, have come under increasing membership criticism and decreasing support in their strategies for fighting medicine's foes. On reflection such a conflict is not only understandable but inevitable.

The time frame within which most physicians function in treating medical and surgical disease is days, weeks, or months. Their work and goals in patient care are morally just. Their formulas for successful treatment are usually predictable.

Unfortunately, when fighting medicine's battles, whether against entrepreneurs in their planning and implementation of managed medical care, legislative meddling in our everyday medical practice, or seeking justice through the courts, our senses of time, morality, and predictability are violated. In these battles time is measured in years instead of months. Morality and logic yield to compromise under the influence of money and politics. Outcomes are less predictable than the weather.

Organized medicine's leadership, physicians and support staff who have experience in this arena, are painfully aware of and prepared to function within the framework of these parameters to accomplish the goals of their membership. However, many of their projects and programs are doomed from the start, but not for lack of worthy aspirations. The leadership underestimates their constituent's naivete with the mechanisms of change within this system and their subsequent reluctance to get involved in future effort in light of past failures.

Most physicians react to change slowly and reluctantly. They have a desire to be in control. Above all else they have a need to succeed. These personality traits leave them ill-equipped to win the war that they wage. Not surprisingly, failures are inevitable and frequent.

The frustration that follows these failures has fueled a counter-productive campaign of retrospective criticism of their leadership as not having pursued the most beneficial programs in the most efficient way. Constructive criticism is healthy. However, the wholesale bickering and backbiting that abound in the house of medicine today threaten the willingness and dedication of its leadership. These physicians and support staff continually sacrifice their time and efforts for medicine's causes. Our enemies could be no better served than for us to drive these men and women from their posts.

An even more sinister threat to medicine is the abandonment of fellowship within our profession. The competition for patients as the result of physician oversupply and the intrusion of government and big business has resulted in an attitude of "every man for himself."

The battle over fee schedules between cognitive and procedural specialists plays right into the hands of our enemies, who think that we all make too much money anyway. This feud further justifies their efforts to lower our incomes.

The most destructive behavior of all is the criticism of a colleague as a tool for building self-esteem. At the least, we lose the respect of our patients. At worst we may instigate an unwarranted malpractice suit.

No one is suggesting cover-ups. On the contrary, the whole medical profession wears a blackeye when substandard medical care is practiced. Such practices should be reported to the appropriate authorities. My plea is that as a subsequent treating physician we all live by "the golden rule."

The challenges that face our profession are simple. First, we must learn to accept occasional defeats as a temporary condition and learning experience in the long range pursuit of our goals. Second, we must all be informed and involved in the process of change. Third, we must learn to funnel our frustration and anger at our real foes, outside of the profession. Finally our greatest strength exists in united support of each other and our elected leaders. Such a commitment essentially guarantees our success.

Kevin M. McAuliffe, M.D.
Guest Editor

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A Rip-Off, Almost!

"This is Dr. Dupe's office, may I help you?"

"I have a personal long-distance call for Dr. Dupe. Will you put me right through?"

"I'm sorry, Dr. Dupe is with a patient right now."

"He's expecting me to call."

"He is? Well, I'll get him for you then."

"Dr. Dupe, there's a long-distance call for you on line 2. It sounds important."

"Hello, this is Dr. Dupe."

"This is Henry W. Martin from Gotcha Incorporated. Dr. Fred, you will be pleased to know that you have won a brand new $37,000 sports car, or a 45-inch big-screen television set, or a pair of round-trip tickets to either Hawaii or the Bahamas, or a 28-foot boat. How does that sound, Dr. Fred?"

"Well, pretty good. . . but I'm in the middle of doing a checkup on a patient."

"And I know how important patients are to you, Dr. Fred, so I will hurry right along with the explanation about your prize. Now you understand — I want it to be perfectly clear — that you will receive only one of the prizes I named, Dr. Fred. But any one of them would be all right, wouldn't you say, Dr. Fred?"

"Yes, but . . ."

"Absolutely, Dr. Fred. Now you probably want to know which one you are going to get, don't you? Well, I can't tell you, because I don't know right now. That will be determined next month when the computer drawing takes place. Dr. Fred, all prizes will be awarded. I forgot to tell you that $3.9 million worth of prizes will be awarded by my client, and the computer drawing and prize money is being monitored and audited by the firm of 'Fake and Rip-Off.' Now let's get down to business. You probably wonder who my client is and why the company can afford to give away $3.9 million worth of prizes, right?

"Well I was wondering. . ."

"Of course you were, Dr. Fred. But let me tell you, this company is opening a network of one-hour film processing labs across the country and wants to introduce this program quickly and rather than spending $10 million on TV promotions has decided to create a sensational news item that will get $12 million of TV time for $3.9 million. So the bottom line is, you have already won a valuable prize and will receive 960 rolls of premium color 35-millimeter film with free processing. You can use as many of these rolls of film yourself as you want, Dr. Fred, and then you can give the rest of them away to your patients, friends, and colleagues. The only thing you can't do is sell the film — you understand this don't you? But just think of the value of this film and the processing alone — to say nothing of the big prize. Now I do need to know your social security number, and your wife's. . .you understand we must report the prize to the IRS of course. And I'll need to know whether to have the prize delivered to your home or to your office. And, oh, there is one more thing, Dr. Fred. The only thing you will have to do is pay the shipping and handling charges along with the state sales tax on the film and processing kits. I'm sure you understand how this is, but it is just a token of the value of the film which you will enjoy for yourself and others, Dr. Fred."

"Well, how much is this tax, shipping, and handling charge?

"You don't have to pay a thing right now, Dr. Fred. In fact, you don't have to pay anything until your film kits are delivered. And by the way, we will imprint your name on the kits at no charge to you, Dr. Fred. Would you like the imprint to read 'A gift to you from Fred Dupe, M.D.' or would you like it to say 'A gift to you from Dr. Fred Dupe'?"

"Well, it doesn't matter much, but I guess the first way is better."

"Now Dr. Fred, do you have any questions?"

"When will I be getting my film and my prize?"

"You can expect to get your box of film within 7 to 14 days. It will be delivered by the United States Post Office, and it will be coming COD. When it arrives, all you have to do is give your mail carrier a check for the shipping and handling charges and sales tax, which we have to charge you even though the order is coming from out of state. Now the total amount of your check will be only $379.42. You may want to have this ready for the carrier. Make it out to the US Postmaster and the name of your city and that's all you need to do. Thank you, Dr. Fred, and congratulations."

Something about all this didn't feel quite right to Fred. Obviously, it would be great to get the free color film. Taking pictures was a fun hobby, especially with his new automatic-focus camera. And who wouldn't want a new sports car, a 45-inch big-screen TV, and free vacation, or a new boat — even if you did have to pay the tax on the gift?

It seemed too good to be true. "And when things are too good to be true, they probably are," Fred thought, remembering the $10,000 check he had written out for the cattle. That was the last time he saw that money, and he never did get to see the cattle he owned, or thought he owned. It was one of those sure-thing tax shelters that would multiply his investment at 42% per year. Several of Fred's colleagues got into the cattle deal too. The cows were part of a limited partnership — a feedlot deal where the feeding was

going to be controlled by a foolproof computer program that would put more weight on the cows than any other cattle feedlot program going. The returns would be great and the turnaround time short — probably just a few months. And then you could cash out or reinvest in more cows.

Well, Fred didn't get to cash out or reinvest. The cows picked up a rare infection, and you can guess the rest.

Fred remembered some other deals that were too good to be true too and realized he was about to be getting a box of film and processing packages that would supposedly be worth several thousand dollars, plus a prize that could be worth thousands more — and all he had to pay was $379.42 when the film arrived.

Fred thought a few minutes and then dialed the state attorney general's number.

"What can you tell me about Gotcha Incorporated and a free film promotion with the promise of one of four expensive prizes?"

"Not much. The computer doesn't show any complaints about a Gotcha Inc. or a Gotcha Company. But I can tell you it smells like a scam."

"That's what I was afraid of — but how does it work?"

"Doctors and others have been the target of several recent telephone scams. There are several variations on the scheme, but this one sounds quite typical — a promise of merchandise, a prize, and a hooker of a COD charge for something coming in a box."

"Well, I still don't see how it works. What do they get out of the deal?"

"They get the money you pay COD and you get a box. It may be full of shredded newspapers or maybe a few rocks."

"I don't get it. Why would anyone pay for a box with worthless contents?"

"If you write out a check to the postmaster, the money goes to the sender."

"But doesn't a person get to open the box before paying the money?"

"No. That's not the way CODs work. You pay first and then get the box. You can't get the money back from the post office — at least not then. And by the time you file a complaint of postal fraud, these guys will be long gone. It's hard to catch up to them. And many who get ripped off are too embarrassed to file a complaint."

"So what do I do now? The box will be coming in a week or so."

"Just refuse it. Don't accept it and don't let anyone in your office pay for the COD. It's very important to notify everyone in your office who is authorized to disburse funds."

"I guess I'm lucky I did some checking."

"You certainly are. And one more thing — while you're talking to your people about fraud, you might want to clue them in on the copy machine toner scam."

"What's that?"

Some calls your office who sounds like the dealer who sold the copy machine to your office and, while talking with one of your people, obtains the serial number of your copy machine and other information about your office equipment. Later that person calls back announcing a special bargain rate on a case of toner for your copy machine or ribbons for your typewriters or computer printers. The unsuspecting person on the phone is urged to authorize a special order to save a lot of money — often COD."

"What's the rip-off on this scheme?"

"The package comes — often from out of state — with shipping notices stating inconspicuously that it is nonreturnable. Unfortunately, the prices of the toner or other merchandise are often not checked against those of the regular supplier, and the caller may be charging four or five times as much as the ordinary prices. If someone fails to pay, threats may be made to sue. The answer to complaints about the inflated prices is often that 'this is a free country and one can charge whatever one wants to for a product.'"

Fred hung up the phone and finished taking care of his patients. It was a busy day.

He felt fortunate to have avoided being ripped off again. As he fell off to sleep that night, Fred's last conscious thoughts were the words, "If it seems too good to be true, it probably is."

Glen C. Griffin, M.D.

The names of the people and companies are completely fictional and any relationship to any person or organization is entirely unintentional and coincidental.

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The Medical Students' Springtime

Springtime to the students in the 127 medical schools in the United States accredited by the Liaison Committee on Medical Education brings the traditional feelings and emotions about which songs and poetry are written. Other emotions and feelings are unique to the senior medical students, the Class of 1988. Remember graduation? Finally, the cherished Doctor of Medicine degree. Graduation day is special in the lives of graduates and especially loved ones because of the ceremony, tradition, and "rite of passage." A day perhaps more elevating in the life of each graduate is MATCH-DAY when prospective graduates learn where they will spend the next phase of their professional life.

On March 23 prospective graduates from the three medical schools in Florida joined the other U.S. graduates in occupying 13,496 of the 19,513 available accredited residency training positions. An additional 2,623 positions were filled by foreign medical graduates, physicians who had graduated in previous years, and osteopathic physicians for a total of 16,119 filled positions.

Each year's graduate continues expanded achievement in completing a more compacted curriculum in the same four-year period. More knowledge of disease, treatment and technology must be mastered before the degree, Doctor of Medicine, can be conferred. Various Board and subject competency examinations must be completed before leaving the life of a medical student and passing on to the life of the new physician.

Each new physician will begin his or her life on the pathway of learning pursuing their career choice with joy and anticipation for the future. Although today's medical school graduate is aware of the problems of professional liability, managed health care, distributive justice between access to health care and payment for health care, concern of the public about physician competence, licensure and relicensure, cost of health care, and, yes, autoimmune deficiency syndrome (AIDS), each graduate is enthusiastic for the future of medicine and believes that THEY can make a difference and THEY will, because THEY believe THEY can. The view of medicine by the graduate of today is not jaded with *our* frustrations and disappointments in changes in medicine and perceived barriers to our continued success of caring for the sick or comforting the dying. Each new physician for their achievement, supported in their enthusiasm and provided encouragement for their success as the new generation of physicians, receives the "baton" and the "lighted lamp." Today's medical school graduate is the harbinger of the future of medicine. Our continued hard work in helping to make medicine better for the public and the profession will ensure our legacy to be a worthy inheritance.

"The heralding of spring brings the anticipation of new life to produce a new harvest — each better than the last. And so goes life's cycle, blending the yesterdays into tomorrows."

Anonymous

J. Lee Dockery, M.D.
Executive Associate Dean
University of Florida College of Medicine

BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

The Physician's Guide to Practice Location by State, 1987-1988

Volume I (Alabama to Kentucky), by O. Sam Ashouri, M.D., 360 pages, price: $32. Doctors Publishing, Inc., Jacksonville, Fla., 1987.

This book is the first of a three volume set which provides a comprehensive guide to elements involved in physician practice locations throughout the country. It may be helpful in assisting physicians in locating a suitable practice site or in relocating. Each chapter covers one state and gives population characteristics, physician characteristics, primary care manpower shortage areas, and HMO data and listing. It also reviews medical practice acts including licensure requirements and Medicare prevailing charges. Physician related activities are summarized from gleanings through the appropriate state medical journal.

The author, O. Sam Ashouri, M.D., practices nephrology in Jacksonville.

Coping With Chemotherapy

by Nancy Bruning, 297 pages, price: $15.95. Doubleday & Co., Inc., Garden City, N.Y.

Nancy Bruning, in this 1985 source book for chemotherapy patients, has attempted to provide a comprehensive guide for those who are advised to take such therapy. As a result of interest stemming from a personal experience with chemotherapy, Ms. Bruning has apparently researched her subject quite extensively. She quotes authorities from many of this country's major cancer treatment centers as well as many experts in related fields.

The text opens with an initial discussion of the general subject of cancer and its treatment as background for the decision of whether or not to have chemotherapy. In addition, the author suggests ways to be sure you are seeing the right doctor and getting sound advice.

This is followed by exploration of the mechanics of chemotherapy administration and of the possible use of adjunctive measures including emotional support, diet, vitamin therapy, and exercise. She then discusses the common side effects of chemotherapy and the best ways to minimize them and cope with them.

The book closes with further assistance to the cancer patient in the form of appendices listing the common chemotherapeutic agents and their effects and potential sources of support to the chemotherapy patient, a glossary of terms, an extensive bibliography, and a thorough index.

For the most part, this book offers good advice, is thorough and well organized, and can be highly recommended as a source of information for the potential chemotherapy patient. The only hesitation this reviewer would have in giving it an unqualified endorsement is a tendency on the part of the author to be somewhat soft on what she refers to as unorthodox or nontraditional treatment. She is apparently not convinced of the potential danger of therapies based on theories that have not had proper scientific evaluation. By the same token, she offers good advice on the qualifications to look for in a person giving nutritional advice (i.e. biochemical education, American Dietetic Association registration, etc.) but then suggests some uses of vitamins and minerals that are not supported by any scientific evidence or recommended by authorities with such credentials.

Such lapses are only a very small part of an otherwise good book and are the sort of thing that could and should be dealt with in physician-patient discussion anyway. It is just such discussion that Ms. Bruning strongly encourages and hopes to improve with this book.

Henry L. Harrell Jr., M.D.
Ocala

Dr. Harrell is associate editor of the Journal and practices internal medicine in Ocala.

Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

Stress in the Medical Family Part II

Last month in my article on stress in the medical family, I used Webster's definition of stress as "the straining force exerted upon a body that tends to strain or deform its shape, or the opposing reaction or cohesiveness of a body resisting such a force." I identified a few of those straining forces that the physician, spouse, and family are experiencing in this ever-changing world of medicine. I also identified ways in which doctors, their spouses and families are reacting to or resisting these forces. Some are working longer hours, increased worry about practices, and the ever-increasing demands and expectations of patients, unanticipated career changes, cessation of certain procedures, and earlier retirements. I also mentioned spouses' attempts to adjust by assuming more responsibilities for the home and children; the children feeling the stress by being more acceptable to peer pressure and acting out sexually and using alcohol and drugs. The family experiences an increase in irritability, depression and marital discord. Sometimes there are attempts to buy happiness by increased consumption of goods which often creates more hostility and alienation, as well as increased economic stress.

I also said it would be nice if we could stop the world and get off. Unfortunately, that is not possible nor would we want to if we could. The problem is that things are changing so rapidly it is nearly impossible to adapt to them quickly enough to not experience significant stress. Also, unfortunately, we tend to look outside ourselves for the solution. We think if we could only change the situation producing stress, we could attain a certain measure of serenity. That is true. If we could change all stressful factors, we could attain serenity. If there were no malpractice problems, if there were no increased demands on family time and resources, the stress would be markedly decreased.

Unfortunately, or fortunately, there will always be changes to which we will have to adapt. Currently, changes are coming so rapidly and are so profound that the medical profession has a sense of loss of control, powerlessnesss, and impotency never before experienced by most of us.

What can we do, then, in the midst of such environment? No question, we will have to keep on trying to control these changing forces through political, educational and other processes. At the same time, we must find ways of experiencing some sense of power and control that we can exercise.

This starts with one's self. Each of us (doctor and spouse) can say, "I'm going to change something that is causing stress in my life today!" For example, I will take inventory of the things I am involved in and shed at least one of these task that is not essential to me. This can proceed until each has the feeling that he or she has done something about stress in his or her life. The second step is an alliance with one's spouse. Together we say, "What can we do together to minimize stress in our lives today?" This process can repeat itself involving other members of the family.

The success of this process depends on not moving too rapidly or involving too many people. The strength of this process is that the individual feels some sense of power, the couple together feels a sense of control and finally the family can say, "We are doing pretty well."

I recognize that all this is done while the world moves on and the problems of the profession become increasingly complicated, but we have to start somewhere. The Chinese proverb tells us, "A long journey starts with a single step." We might also draw on the prayer of serenity, "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference."

Mrs. James A. (Mary) Alford
Tallahassee

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

JUNE

Meeting of the Florida Hand Society, June 3-4, The Breakers, Palm Beach. Contact: Mas Massoumi, M.D., (305) 655-9455.

Caduceus Risk Management Seminar, June 4, Sheraton Design Center, Dania. Contact: James Seigler (305) 735-5430.

Basic Trauma Life Support Provider Course, June 4-5, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

8th Annual Cancer Conference, June 9-11, Longboat Key. Contact: Paulette Varney (813) 974-2745.

Partners in Perinatal Health: Expanding the Horizons, June 9-11, Hyatt Orlando, Kissimmee. Contact: Sister Jeanne Meurer (813) 974-4860.

Breastfeeding — Science Behind Success, June 13-15, Hilton Hotel, Lake Buena Vista. Contact: Carol Kolar (219) 462-42027.

39th FAFP Annual Scientific Assembly, The Breakers, Palm Beach. Contact: Linda Keach (904) 743-6304.

Risk Management Seminar, June 18, Hyatt Regency, Tampa. Contact: M. P. Demos, M.D. (800) 431-3878.

Doctor-Patient Relationships and Their Effect of Litigation, June 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D., (813) 254-1020.

Cuban Medical Convention, June 30, Intercontinental Hotel, Miami. Contact: Hilario Anido, M.D. (305) 372-4743.

JULY

Family Practice '88, July 5-8, Hilton Hotel, Orlando. Contact: Shelburn Wilkes (305) 898-1695.

Basic Trauma Life Support Provider Course, July 9-10, USF College of Med., Tampa. Contact: James Hillman, M.D. (813) 251-6911.

8th Annual Cancer Conference, July 9-11, Colony Beach Resort, Longboat Key. Contact: Henry A. Azar, M.D. (813) 974-3133.

Breastfeeding: Science Behind Success, July 13-15, Hilton Hotel, Lake Buena Vista. Contact: Carol Kolar (219) 462-4027.

Basic Trauma Life Support Provider Course, July 23-24, USF College of Med., Tampa. Contact: James Hillman, M.D. (813) 251-6911.

Risk Management Seminar, July 30, Holiday Inn, Ft. Lauderdale. Contact: M. P. Demos, M.D. (800) 431-3878.

AUGUST

Otolaryngology for the Practicing Pediatrician, August 4-7, Mariner's Inn, Hilton Head Island, South Carolina. Contact: Debbie Shealy (803) 798-6207

ACLS Provider Course, August 6-7, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911

Fundamental & Clinical Aspects of Internal Medicine, August 7-20, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Arrhythmias: Interpretation, Diagnosis and Management, August 19-20, Grand Cypress Hyatt, Orlando. Contact: Deborah Wilderson (800) 421-3756.

Risk Mamagement Seminar, August 20, Holiday Inn, Coral Gables. Contact: M.P. Demos, M.D. (800) 431-3878.

SEPTEMBER

19th Annual Pediatric Labor Day Symposium, Sept. 2-4, Pensacola. Contact: Garth Grove, M.D. (904) 474-7101.

Magnetic Resonance Imaging A Technologists New World, Sept. 15-17, Holiday Inn, Lake Buena Vista. Contact: Martin Silbiger, M.D. (813) 974-2538.

Current Concepts in the Diagnosis & Treatment of Adult Heart Disease, Sept. 16-17, New World Landing, Pensacola. Contact: Phyllis Connerley (904) 478-4460.

ACLS Instructor Course, Sept. 17-18, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

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DEPARTMENT OF MEDICINE

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"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

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For registration and information write to:
J. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101 Telephone: (305) 547-6063

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The Journal of the Florida Medical Association, Inc.

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RETIRED OR SEMI-RETIRED ORTHOPEDISTS to work in Tampa. Part-time office work with flexible hours. Reimbursement for travel expenses. No patient care involved. Must have active Florida license. Not a malpractice or legal organization. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1461, Jacksonville, FL 32203.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking Full and Part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

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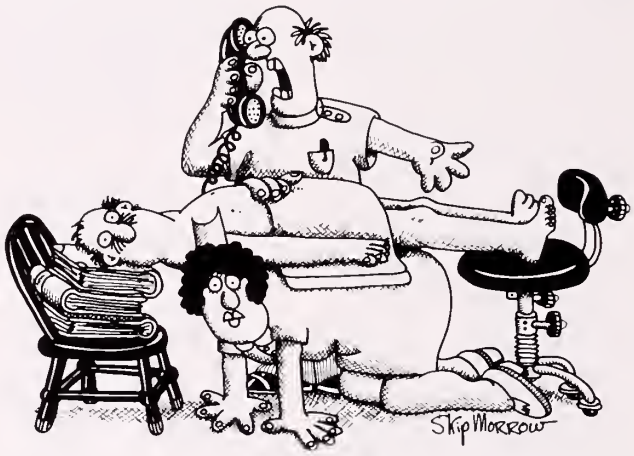

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Feature Editor — **Dale C. Havre, M.D.**

Why Not Pay Parents to Stay Home?

It is touted as the logical solution to a national crisis. The proponents wonder how we can survive as a nation without it. The opponents argue that we will never survive as a great nation with it. The subject is federally subsidized day-care for children of working parents, and there had better be a reasonable compromise. The country cannot afford to support another multibillion dollar bureaucracy, nor can it relegate our most precious resource, our children, to the back burners of parental commitment.

Because there are some 34 million American children who live in single-parent homes or who have both parents working, it is estimated that by the year 1990, 12 million preschool children will need the services of thousands of part-time, surrogate parents. Senator Christopher Dodd of Connecticut would like to tax us $2.5 billion to set up a massive day-care bureaucracy, complete with the predictable myriad regulatory boards, and then raise taxes ad lib to keep the concept afloat. There is an alarming similarity to the hype and jargon that surrounded the birth of Medicare a couple of decades ago.

Instead of raising all this money to create and maintain an artificial home environment for the nation's little ones, why not give the money to the real parents so one of them can stay home and take care of his or her own children? If the government can afford to pay a farmer $4,722 a year not to plant 38 acres of corn or 48 acres of wheat, then doesn't it make sense to pay a biological mother or father not to go to work, if their presence at home will benefit the child physically and emotionally? After all, real parents are more likely to have the child's best interests at heart than a day-care worker, no matter how well motivated that worker might be.

Whenever a crisis arises in this country, an alarming number of people believe that heaping money on the problem will make it go away. That, obviously, is how too many politicians think and is one reason why the United States is in serious financial trouble.

If experts in child psychology agree that the first five or six years of a child's life, the preschool years, are the most important in shaping his/her personality, values, behavior and sense of worth, then would it not be in the national interest to provide the necessary funding to allow at least one, real, loving parent to stay at home during those formative years? Since Uncle Sam can't draft parents to serve their time in the diaper-pail trenches, then the government should at least have the option of paying one of the parents to serve the country as a day-care soldier on the home front. Indeed, for selected parents there should be provision for hazardous duty pay, because the supervision of some tykes can be more harrowing than a Marine obstacle course. After all, parenting is one of the toughest, most challenging jobs in the world. The requirements for being a good parent far exceed those needed for most jobs. It takes more than a modicum of talent and determination to pull it off successfully. But, surely, a child who senses that he is worthy of the effort by his own parent(s) is learning to feel important in a healthy way. How preferable that seems to establishing a monstrous bureaucracy devoted to the impossible task of recruiting, training, regulating and paying surrogate mothers and fathers of unwarrantable effectiveness.

Unfortunately, there are many situations in which both parents must work to keep body and soul and family together, even if direct federal subsidies were available to them. And for the millions of single mothers who are trying to raise their preschoolers without help from the biological fathers, there is little choice but to go to work. But there will always be a group of parents who will never volunteer to stay at home with their young offspring, even when they can afford to do so. It is for the first category of parents that decent child-care centers should be established. As far as the hard-core, electively out-of-home workers with preschool children are concerned, perhaps the federal government should also invest in a chain of repair shops that are qualified to straighten out the twisted priorities of parents who willingly relegate the shaping of their children's minds to certified strangers.

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Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L738 Date of issuance Apr. 1987

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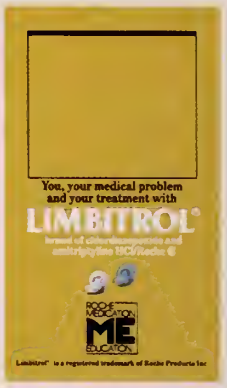

Roche Medication Education Booklets supplement your instructions to patients. So forget **ME** not. The Limbitrol® (chloradiazepoxide and amitriptyline HCl/Roche) booklet is part of The Roche Medication Education Program.

This important program helps your patients remember and understand:

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- The importance of staying with the prescribed course of treatment
- What foods and drinks to avoid
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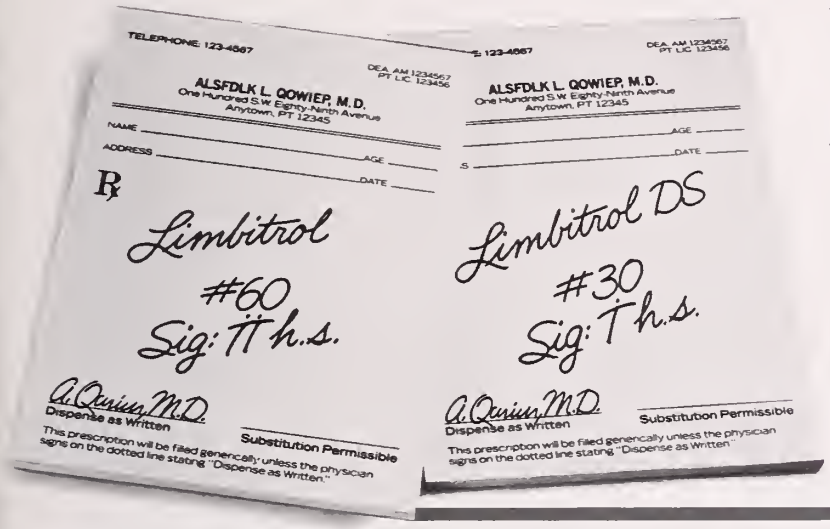
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓥ

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓥ

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol® Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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- First-week reduction in somatic symptoms[1]

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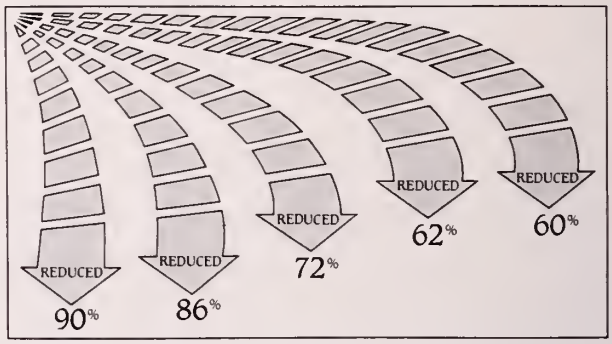
Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

Limbitrol® DS

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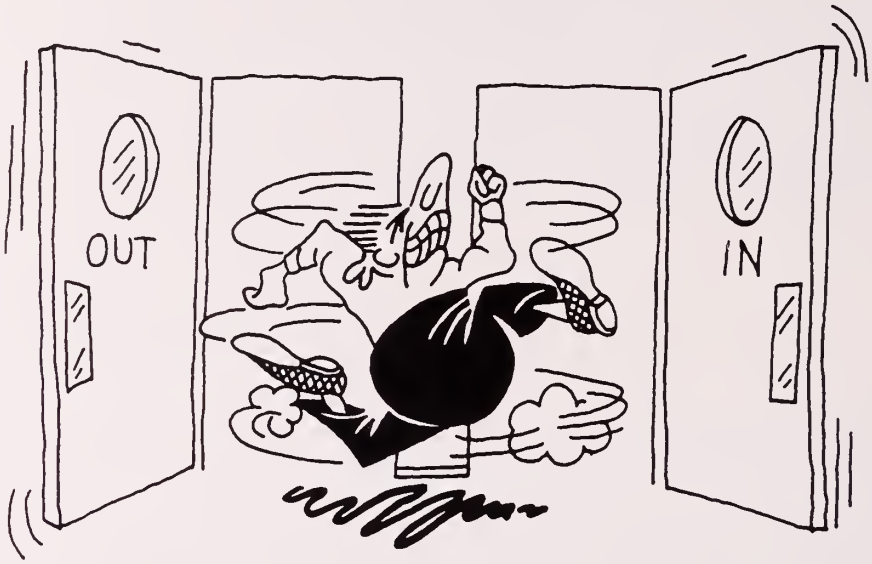

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COVER

Early-morning fog temporarily shrouds another inimitable Florida sunrise along the Sunshine State's east coast. The work of FMA staffer Robert Seligson, this month's cover was photographed at South Ponte Vedra Beach near Jacksonville and offers us a fitting proclamation of the summer season.

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References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see OVERDOSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

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Bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 Bottles—100 tablets each	NDC 0083-0165-65
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Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

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PRESIDENT'S PAGE

Learning How to Win

Many of you are golf fans or at least have watched major championships on television and heard the commentators remark how difficult it is for a rookie to win his first tournament. He can be enormously talented, yet have great difficulties achieving that first victory.

We are at the threshold of our first major victory — the amendment to the Florida Constitution limiting general damages to $100,000 in all tort liability cases. This victory is ours to lose. The public is with us, we have an outstanding campaign staff, and the timing is right. Victory is at hand!

We are lacking in only two key areas and only YOU, our members, can decide whether you are ready to step into the arena and claim the prize. The key areas we are missing are:

1. 90,000 more valid signatures, and
2. Your $500.

I fully understand the reluctance that some have. You continue to harken back to 1984, fearful that we will once again fail, but 1984 is history and we must move forward. There are several major hurdles we have crossed this time.

1. We are on the ballot as soon as we get the necessary 343,000 valid signatures.
2. Our members and our auxiliary have already gathered FOUR TIMES the number that we got in 1984. We have not had to go outside our medical family to obtain any of the 257,000 signatures to date.
3. The people in Florida are better educated regarding the liability situation than ever before in history.

Without your complete cooperation, both in continuing to ask your patients to sign petitions and sending your $500 assessment, we will surely fail. Our very fine FMA staff, your county staff, and many dedicated auxilians have gone the extra mile. It is now in YOUR hands.

I am pleading with you to get involved. This may well be our last battle in the long-standing war with our adversaries. I know I can count on each one of you. Let's get that first major victory.

PHYSICIANS, SCHEDULE SOME TIME FOR YOUR COUNTRY.

Many physicians would like to devote some time to their country in a local Army Reserve unit. We know that making a weekend commitment can be difficult for most physicians. So it is practical for the Army Reserve units to be flexible about time. It's worth discussing.

Incidentally, in addition to satisfying your own desire to serve your country, there are exceptional opportunities to do something totally different from a day-to-day routine. Opportunities to study new areas of medicine, meet new people in your specialty, and be a part of one of the world's most advanced medical teams.

Discuss the opportunities with our Army Medical Personnel Counselor.

FOR SURGEONS LOOKING FOR A CHALLENGE.

Your challenge could be the Army Reserve unit near you. It's a unit that requires the services of surgeons.

You may wish to explore the challenge of teaching in a major medical center. You may wish to explore the special challenges of your specialty in triage. Certainly you'll be confronted by challenges very different from your daily routine.

You'll also have an opportunity to participate in a number of programs in which you'll be able to exchange views and information with other surgeons from all over the country.

The Army Reserve understands the time demands on a busy physician, so you can count on us to be totally flexible in making time for you to share your specialty with your country. We'll arrange your training program to work with your practice.

To find out about the benefits of serving with a nearby Army Reserve unit, we recommend you call our Army Medical Personnel Counselor.

PHYSICIANS, THERE ARE TWO KINDS OF FLEXIBILITY IN THE ARMY RESERVE WE THINK YOU'LL LIKE.

One, time. We know how tough it is for a busy physician to make weekend time commitments. So we offer flexible training programs that allow a physician to share some time with his or her country. We arrange a schedule to suit your requirements.

Two, the opportunity to explore other phases of medicine, to add a different kind of knowledge—the challenge of military health care. It's a flexibility which could prove to be both stimulating and rewarding, with the opportunity to participate in a variety of programs that can put you in contact with medical leaders from all over the country.

See how flexible we can be, call our Army Medical Personnel Counselor.

ARMY RESERVE. BE ALL YOU CAN BE.

HERE'S ONE DOCTOR WHO WON'T PAY HIS MALPRACTICE PREMIUMS THIS YEAR.

The Army covers his premiums. Since he's an Army Physician, there are a lot of worries associated with private practice that he won't have to contend with. Like excessive paperwork, and the overhead costs incurred in running a private practice.

What he will get is a highly challenging, highly rewarding experience. The Army offers varied assignments, chances to specialize, or further your education, and to work with a team of dedicated health care professionals. Plus a generous benefits package.

If you're interested in practicing high quality health care with a minimum of administrative hurdens, examine Army medicine. Talk to your local Army Medical Department Counselor for more information

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EDITORIALS

Legalizing Drugs Is Moral Cowardice

The campaign against illegal drugs took on a new and ironic twist with the recent announcement by prominent public figures of a proposal to legalize the sale of these drugs. Despite all the rhetoric, threats, interdictions, and billions of dollars spent yearly, the war against drugs has been perceived so far as a tragic failure. There is also mounting public concern about the drug problem, with close to 20% of Americans saying that it is the paramount issue that needs to be addressed by national leaders. Against this backdrop, the proposal to decriminalize the sale of illegal drugs has been advocated to foster further national debate on the issue.

The reasons advanced for legalizing the sale of illegal drugs sound persuasive, at least on the surface. Advocates argue, for example, that the money now being spent for law enforcement and interdiction can be channeled into increased public education and new treatment programs; that the huge profits from sale of illegal drugs will disappear along with the crimes and violence spawned by the drug problem; that diplomatic relations with our allies which have been ruffled can be restored; and that, like the abolition of Prohibition, the legal sale of drugs will make it much easier to regulate their use by the public.

But most of these arguments, on closer scrutiny, appear to be naive and untested assumptions. They also ignore the fact that most Americans believe the legal use of such drugs is morally offensive and may destroy the social fabric of the nation.

Educating the public about drug addiction is fine, but I think most Americans, including addicts, are already well informed about the dangers. Putting up more treatment and rehabilitation centers will help temporarily but gives no guarantee that people will shy away from drug use. Besides, the expenses involved will be much, much more than those that have been projected. Drug profits may not entirely disappear but more likely will be passed on from the drug lords to whoever will be authorized to sell the drugs. As for ending diplomatic threats to those nations that have been supplying illegal drugs in this country, most Americans will view this more as political expediency rather than a diplomatic triumph. Finally, any parallel to the Prohibition era is ridiculous; the end of this period did not curb the public appetite for drinking but has contributed to the high incidence of alcoholism in this country.

Legitimizing drugs, to the contrary, may worsen the problem of drug addiction in this country. The majority of those who use drugs are hard-core addicts and there is no reason to think that they will drop their habit particularly if drugs can be obtained legally. The millions on the fringes who periodically use drugs for recreation and those who have abstained because of previous restraints will find unlimited freedom to experiment with drugs in the absence of any legal impediment or social restraints.

Furthermore, the logistics of implementing such a proposal have raised a lot of difficult questions even among those who favor the legal sale of drugs. For example, who would be authorized to sell these drugs? Would it be physicians, pharmacists, or licensed drug agents? In any case, the potential for fraud and profiteering remains. Who should be allowed to buy these drugs? Setting age limits will be as laughable as the various liquor statutes which have not prevented anybody from purchasing an alcoholic drink. For those allowed to buy these drugs, should there be limits on how many they can buy? Finally, should we legalize all hard drugs including cocaine, heroin, and marijuana?

Apart from being unrealistic, unworkable, and socially abominable, legalizing drugs is basically un-American. It calls into question the toughness of our character and the moral moorings of our society. We have always prided ourselves as a people who have won every war we fought: against communism and foreign domination, racism and injustice, poverty, and human indignity. Legalizing drugs is the equivalent of throwing in the towel, and it is the highest form of moral cowardice that we can commit as a nation. Nobody ever said that winning the war against drugs is easy; it will test to the limits our guts and character as a people. But we do not need to lose either one of them in the process.

R. G. Lacsamana, M.D.
Editor

Too Many Doctors? Maybe It's a Blessing

The forecast of a doctor glut may or may not come, depending upon who physicians listen to. The Graduate Medical Education National Advisory Commission (GMENAC) said it will happen as early as 1992; Dr. William Schwartz countered recently no such thing is going to happen. Those who are skeptical of Dr. Schwartz have powerful arguments on their side: 18,000 new physicians are graduating yearly from the nation's medical schools, with only a handful of these schools having reduced their enrolments; close to 4,000 Americans come back annually with their medical degrees from the Caribbean, Mexico, Europe, and the Far East; and FMGs continue to migrate here, though not in big waves as before. The annual listings for physicians in the Yellow Pages also confirm the trend that their numbers are soaring faster than they did in the past.

Assuming that GMENAC is right and Dr. Schwartz is wrong, why would physicians complain about their swelling numbers? Too many doctors, it is argued, is voodoo economics and makes for bad public policy. It does not make sense to educate a physician for 11 to 15 years and then expect that he or she would get a decent economic return when the supply outstrips the demands. In addition, unfettered competition from an overabundance of doctors may lead to unethical practices, unnecessary services, and poor medical care.

Furthermore, some physicians may not be able to maintain certain skills if the opportunities to see patients become limited. Fair enough. These are all sensible arguments. But what about the other side of these arguments? Have we ever thought that having more doctors than we have now may be a boon and a blessing? The potential benefits are many, but I can think of at least three compelling ones.

First of all, the quality of life for physicians will improve vastly. Physicians keep talking about improving the quality of lives for their patients but conveniently forget about their own. I concede that a lot of physicians have obsessive-compulsive personalities but that is no reason for them to keep working like resident-physicians in training. Having more doctors around will eliminate the daily overbooked office schedules, the long waiting periods for patients, and mass suspension of privileges by the Medical Records Department. Most of all, seeing less patients means having less hassles with the bureaucrats, more happy families, and perhaps more years of productive retirement.

Secondly, altruism will find full flower again in the practice of medicine. Most of us entered our profession imbued with high ideals of service, but some of us also get intoxicated easily with the material rewards of medical practice. There is nothing wrong with making money but the public is apt to view that in a different light. Even with a projected reduction by 25% of their incomes, most physicians will still be able to make a good living, perhaps minus that BMW, the condo in the mountains, or the yearly trip to Aspen. Some of us may even stop bitching at our colleagues who do all the procedures and get all the money for doing less than we do.

Finally, physicians will have more opportunities to diversify and develop more fully their other talents. Physicians as a group are known for their high IQs, their creativity, and other assorted talents but then most get bogged down by the narrow focus of their profession. Practicing medicine is like having a mistress: the demands are many but there is no easy way to get out of them. Having more free time will allow physicians to explore their other areas of interest and perhaps even give lawyers, another overpopulated tribe, a run for their money in such fields as politics, government, and public service.

I know a lot of physicians will still be cynical and will dismiss the perceived benefits of a doctor glut as nothing but illusory. Maybe so. But I still refuse to believe Dr. Schwartz and his rosy prognostication of the future. Perhaps he is trying to assuage our anxieties and calm down our paranoia. 1992 is not too far off to tell whether he is right or not. In the meantime, I will start preparing for my blessings.

R.G. Lacsamana, M.D.
Editor

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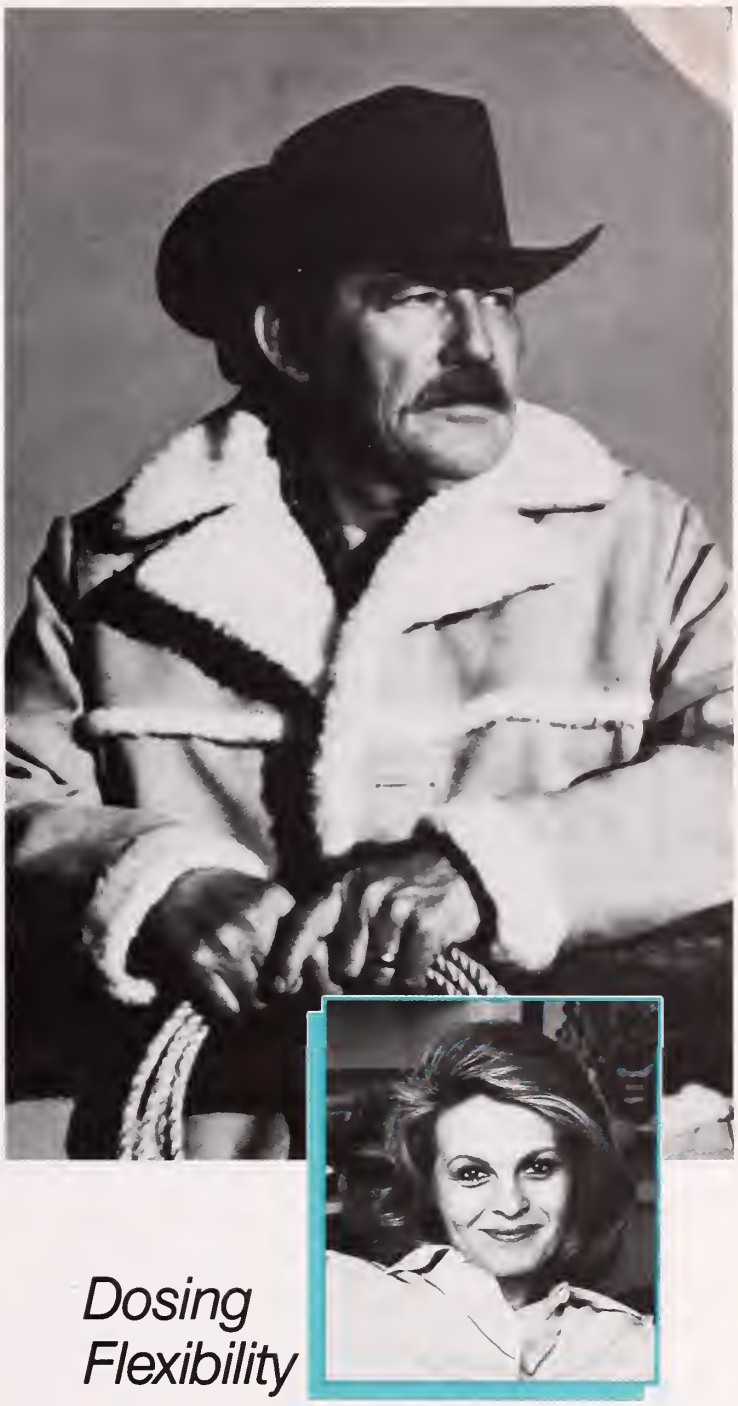

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CHORIONIC VILLUS SAMPLING:

An update from The Genetics Institute of Florida

Encouraging new data indicate that the risk factor for the first trimester prenatal diagnostic technique Chorionic Villus Sampling, is less than previously thought.

A recent study by Laird Jackson, M.D., director of the Department of Medical Genetics at Thomas Jefferson University in Philadelphia and an associate of the Genetics Insitute of Florida, indicates that the procedure-related loss rate associated with CVS, which is performed in the ninth to eleventh week of pregnancy, is approximately one percent when adjusted for the gestational age of the fetus. This compares favorably to the loss rate experienced with amniocentesis.

Other important facts about CVS include:

- Hundreds of congenital diseases can now be detected with CVS.
- Over 35,000 procedures have been performed worldwide.
- In addition to performing early amnios from 13.5 weeks on, the Genetics Institute of Florida has now performed hundreds of CVS procedures. Rapid results are available.
- Directors Jay Trabin, M.D. and Gene Manko, M.D., completed an intensive training program with Dr. Laird Jackson prior to opening the Institute.
- Genetics Institute is the first and most comprehensive private genetics counseling and prenatal diagnostics facility in the Southeastern United States.
- Genetics Institute performs comprehensive genetics counseling as well as Level II Ultrasound

The Genetics Institute of Florida
1401 Forum Way, Suite 200
West Palm Beach, Florida 33401
(305) 697-4200

Genetics Institute of Florida

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Gene Manko, M.D., FACOG
Members of the American Society of Human Genetics
Genetics Counselor: John Bagnasco, B.S., M.S.
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Consulting Physicians: Laird G. Jackson, M.D., Geneticist
Mitchell Golbus, M.D., Geneticist
Joseph Schulman, M.D., Geneticist
Ron Wapner, M.D., Perinatologist

LETTERS & VIEWPOINTS

Tuberculosis — Threshold of an Epidemic?

Tuberculosis is perhaps the supreme example of an opportunistic infection. It is, therefore, not surprising that individuals infected with the AIDS virus (HIV) develop tuberculosis at a rate which has come to have an alarming public health significance. It is the only major life-threatening disease HIV infected individuals develop which is readily spread through casual contact to others. Nationally 4.6% of AIDS victims have been reported to also have tuberculosis — in San Francisco 1.88%, New York City 5.2% and in Florida, through 1985, 10%. These are the rates of tuberculosis in confirmed AIDS cases. The rate in HIV infected, not AIDS confirmed, may be as high or higher. In Dade County, in 1986, almost a third of the males age 25-34 with confirmed tuberculosis were HIV positive.

Life-style education has finally reduced somewhat the spread of HIV among the homosexual community but has not had a noticeable impact upon the spread among IV drug users, prostitutes or the heterosexual with multiple partners. Since San Francisco AIDS cases occur in large part among homosexuals, it can be anticipated that the rate of HIV-related tuberculosis may decline there in the future. For Florida, where AIDS cases are more likely to be heterosexual or drug abusers, a decline is not foreseen.

Before the advent of AIDS, tuberculosis in the United States showed an annual steady decline in case rate. For the three years prior to 1985 the rate averaged 6.6% a year. In 1986 it rose 1.1%.

In Florida the tide changed even more dramatically from an average decline of 6.8%/year prior to 1985 to a 2.5% rise in 1985, 1.6% in 1986 and 3.9% in 1987.

The implication of this is sobering. Dr. Joyner Sims, director of the Florida AIDS program, predicted in December 1987 that AIDS cases in Florida would continue to double annually through 1991. The cumultive figures are as follows:

Year	Cumulative AIDS Cases
1987	2000
1988	4000
1989	8000
1990	16000
1991	32000

Assuming 10% of AIDS cases continue to develop TB, there will be 200 AIDS-related TB cases in Florida in 1988, 400 in 1989, 800 in 1990 and 1,600 in 1991. These figures do not include pulmonary tuberculosis developing in the vast reservoir of HIV infected individuals who do not meet the CDC criteria for AIDS diagnosis. Presently only extra-pulmonary tuberculosis in HIV infected individuals qualifies for this diagnosis. In Florida the majority of HIV infected individuals who develop TB have pulmonary disease (59%).

Assuming that tuberculosis in the non-HIV infected population continues to decline at the pre-AIDS rate of 6.8% a year in Florida, we can predict the number of tuberculosis cases for Florida to be as follows:

	Non-AIDS Related TB			AIDS Related TB		Total TB Cases	
Year	No.	Rate				No.	Rate
1987	1427	11.8	+	159	=	1586	13.1
1988	1362	11.0	+	200	=	1562	12.6
1989	1306	10.3	+	400	=	1706	13.5
1990	1247	9.6	+	800	=	2047	15.8
1991	1182	8.9	+	1600	=	2782	20.9

By 1991 there will be 1,196 more cases of tuberculosis than in 1987.

The situation will probably be worse. The calculations reflect tuberculosis in AIDS cases and in non-HIV infected individuals. They do not include tuberculosis in HIV infected nor reflect the unknown impact of the spread from HIV infected to the non-HIV infected population.

For the first quarter of 1988, there were 390 cases of tuberculosis reported in Florida, 38 more than in the first quarter of 1987, an increase of 10.9%.

What can we do to stop the resurgence of tuberculosis? First we must be aware of this disease, consider it as a diagnostic possibility and perform the studies necessary to diagnose it. Effective chemotherapy is readily available and its administration should be supervised when less than total compliance is anticipated.

HIV positive individuals must be screened for tuberculosis infection and given appropriate treatment or preventive therapy (minimum 12 months in each case) if found to be infected. Tuberculin reactors must be evaluated for HIV risk factors and screened if indicated. Tuberculosis cases and suspect cases receiving therapy likewise must be screened for HIV infec-

tion and treated appropriately. Finally persons who have been given preventive therapy or treated for tuberculosis and subsequently become HIV infected must be reevaluated to determine whether additional antituberculous therapy is indicated. While it is yet too early to determine how large a problem this will become, there are currently several cases of tuberculosis recurring after apparent adequate treatment following HIV infection.

All of this will require money and personnel. The Community Tuberculosis Control Services has submitted grant proposals to the federal government totaling more than $1,000,000 to help in reducing AIDS-related tuberculosis. This alone will not do the job. Additional expense and personnel will be required and necessarily furnished by both the public (Department of Health and Rehabilitative Services) and private sectors of medicine.

Marianne B. McEuen, M.D.
Acting Medical Director, Community Tuberculosis Control Service, HRS
Jacksonville

Health Planners Should Be an Endangered Species

It appears the government's threat was right.

About 25 years ago the president of the Escambia County Medical Society returned from Washington with disturbing news. He told the members of our Society: "The government people bluntly told me that in 25 years they would control the practice of medicine throughout the United States, tell us who we must see, how much we can charge and how long we can keep them in the hospital. 'We'll dictate to the profession of medicine and there is absolutely nothing you can do about it.' "

Two or three irate, shocked members jumped to their feet. "They can't do this. Who the hell do they think they are? Hell, we're private physicians, they can't control our profession."

Our president smiled and said, "That's what I tried to tell these health planners but they said 'wait and see.' " Most of us could not believe such a dire threat and assumed that some young socialist planner had been simply bragging. How mistaken we were!

Along came Medicare and Medicaid offering help to older citizens and those financially limited. Gradually these programs were integrated into our practices. Many physicians have been disillusioned by them. My secretary once told me, "Doctor, we aren't getting any money from Medicaid. They owe us around $3,000 on old bills." Our claims came back marked "Denied." For a doctor who had spent most of a lifetime caring for low income patients, I was angry at such high-handed denial. I wrote the Tallahassee office, "If there is anyone in your office who has an I.Q. of 90 or above, I would appreciate some explanation for the cavalier way you treat my bills." No reply. I wrote again. "I thought you people were to help doctors provide medical care for poor people. Why don't you pay your bills?" No reply. Some months later, some fellow in a group conversation asked why Medicaid used ICD9 nomenclature while the rest of medicine used DSM III. I was reminded of the comment often heard in the Navy during World War II, "It doesn't make any sense at all — it's just policy."

An experience with Medicare was equally confusing. Bard urostomy bags were $138 for a package of 50 at a local drug store. Two years ago, Blue Cross/Blue Shield returned $108 of the $138 which appeared to be a fair participation. Last year, three months after the bill went in, back came a check for $9.83. I immediately wrote them that their office was really screwed up. Would they have someone else handle the bill? A month or so later I got a nice apologetic letter saying how sorry they were and the total refund should have been $32 and please find enclosed a check for $22.17.

After fighting the bureaucracy and slowly losing, I chose to withdraw. For example, a bill for $90 submitted through proper channels brought payment of $22.50. Another bill for $50 resulted in a check for $12.53. Now, in our office, we set low fees and ask patients for payment, then fill out their claims to the government. CHAMPUS is somewhat better and claims are being paid with a reasonable delay. The Veterans Administration is by far the most prompt of any government agency and it does not quibble about reasonable fees. Workers' Compensation cases are much more detailed and require longer reports but they do pay their bills without argument or delay.

In a small city where the cost of living is well below national levels, one would expect medical fees to be lower. One hears stores from patients and some may be true. If they are, then perhaps the public does not have a basis for complaint. One patient reported his ophthalmologist does eight implant cases a morning, 15 minutes per case, for a fee of $1,600 each. Another patient reported being charged $175 for a short psychiatric consultation when he was in inpatient on the medical ward. An elderly lady said her female internist charged $60 daily for a ten minute visit each morning when she was still in hospital. These fees may be considered quite modest in larger cities but in a small southern city they seem quite high to patients who sense this is why their insurance premiums are increasing.

A few years ago the Florida Medical Association

proposed a constitutional amendment that would put a cap on a certain type of damages. The Supreme Court threw out the proposed amendment saying it covered two points rather than a single point which the law required. The idea developed in the public's mind that since the Supreme Court members were all attorneys, the doctors and the public would never have a chance to get a change in the law, that is, the Court would always support its fellow attorneys who, of course, were strongly opposed to any limitations of awards since they always got a healthy slice.

Not all attorneys will rush to file suit if a reasonable settlement can be arranged between the aggrieved and the doctor. This is more in accord with the plan that operated a short time where a three person group reviewed the patient's complaint and made a recommendation for peaceful settlement.

Some doctors are leaving Florida or closing their offices, not because of health planners but insurance companies. Neurosurgeons are declining to provide coverage to emergency rooms. Charity patients stand ready to sue if the result of their medical care is not satisfactory. Obstetricians get sued if a newborn in not healthy and all the parents expected.

Social planning does foul up. In 1968 the Health Manpower Act authorized federal support for new medical schools and more primary care physicians. No long-range plan existed as to the results of this infusion of government money. The GMENAC report said there would be 70,000 more doctors by 1990 than could reasonably be needed. By 2000 the excess would reach 145,000.

Medical school enrollments are decreasing and understandably so, but it's about time. The government opened the floodgates to foreign physicians and students who completed their training and then chose not to return to their country of origin. Our county medical society had 165 physicians when I was president in 1971. We now have 385 and the city had not doubled in population in the last 16 years.

The HMOs and other alphabetical agencies are trying to meet the public need for medical care by standardizing fees, reducing hospitalization, providing lower cost medications and encouraging enrollments on the basis of reduction in the cost of medical care. Some of these organizations are proving popular while others are losing customers.

Increased pressure from health planners is causing many doctors to change their career plans. Many opt for the 40 hour week, no collection problems, assured vacation time and insurance coverage provided. Many cardiovascular surgeons, neurosurgeons, anesthesiologists, radiologists and pathologists prefer their own entrepreneurship with its greater financial rewards. A man whose gross income is several hundred thousand dollars or more can afford insurance coverage that costs from $50,000 to $100,000 a year. Less financially competitive men settle for salaries. The military services, Veterans Administration and many state and university jobs are attractive to less financially ambitious physicians.

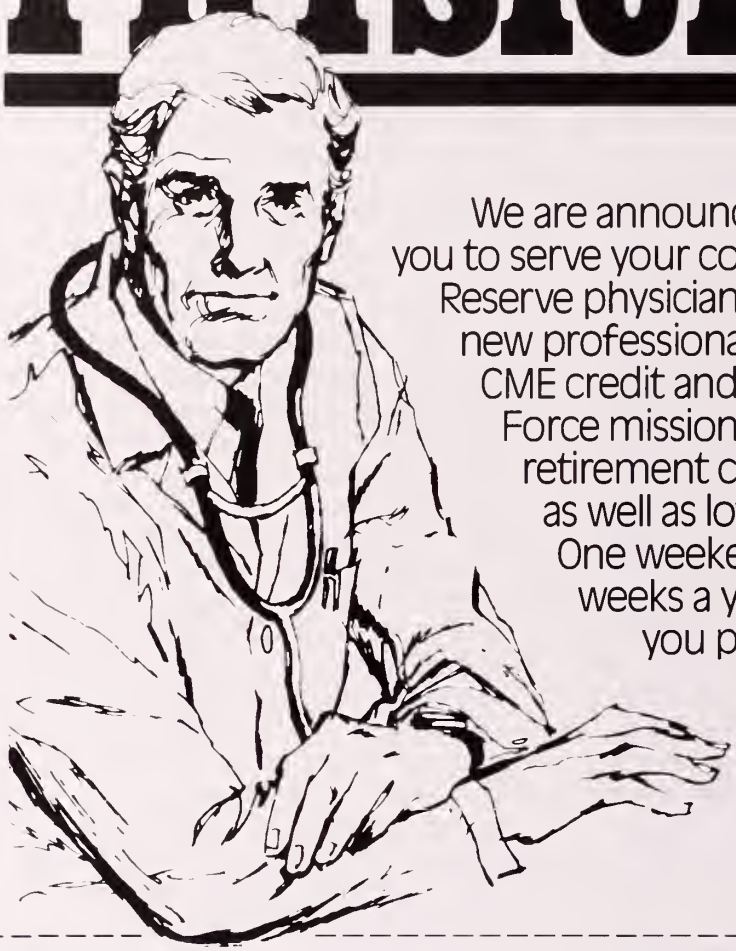
The handwriting is on the wall for the very high incomes. Corporate medicine has a definite interest in the "bottom line" but the plan administrators will be standing by eagerly when the melon is cut. I think I would advise a young graduate, intent on a medical career, to join one of the services, get graduate training in his chosen field, do his 20 years of professional service, see the world and retire at 45 to enter private practice. He could keep his fees in reach of his patient population, be active in professional associations and retire in his 60s with a comfortable lifestyle. He might not have a yacht but a lot of contemporaries won't either.

After a wonderful 22 years in the Navy Medical Corps, broad travel, Board certification, a moonlight civilian practice for a number of years and now 25 years in private practice, it seems so reasonable to say that I'm not leaving the profession of medicine, it's leaving me. It's getting the government control those health planners threatened years ago. It has lost much of the admiration as a career that medicine used to have. Young doctors tell me nurses wear jeans and sweatshirts on night duty and do not show the former courtesy of rising when staff physicians appear on their hospital wards. Government agencies slash reasonable bills to an insulting degree and patients look for ways to sue, hoping to find an attorney anxious for his 40%.

I'm about to quit. In my 47th year, practice is not as much fun and satisfaction as it used to be. I hope the two lawyers in my family continue their highly ethical practice and the physician son continues his vigorous and demanding career. I hope when the telephone rings now it is a buddy looking for a golf partner for Saturday morning instead of what the telephone brought in years gone by.

Philip B. Phillips, M.D.
Pensacola

PHYSICIANS



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Vicodin® provides greater patient acceptance

COMPARATIVE PHARMACOLOGY OF THREE ANALGESICS

	CONSTIPATION	RESPIRATORY DEPRESSION	SEDATION	EMESIS	PHYSICAL DEPENDENCE
HYDROCODONE		X			X
CODEINE	X	X	X	X	X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

- Vicodin offers: less nausea, less sedation, less constipation.

...and longer lasting pain relief— up to 6 hours.

- Vicodin contains hydrocodone not codeine. In one study, 10 mg. of hydrocodone alone was shown to be as effective as 60 mg. of codeine.[1]
- In a double-blind study, Vicodin (2 tablets), provided longer lasting pain relief than 60 mg. of codeine.[2]

Plus...

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- Dosage flexibility—1 tablet every 6 hours or 2 tablets every 6 hours (up to 8 tablets in 24 hours).

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hydrocodone bitartrate 5 mg. (Warning: May be habit forming) with acetaminophen 500 mg.

The original hydrocodone analgesic.

Specify "Dispense as written" for the original hydrocodone analgesic.

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Drug Abuse and Dependence: VICODIN® is subject to the Federal Controlled Substances Act (Schedule III). Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN should be prescribed and administered with the same caution appropriate to the use of other oral-narcotic-containing medications.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing.
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.
Information For Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: The CNS-depressant effects of VICODIN may be additive with that of other CNS depressants. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.
Labor and Delivery: Administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk; therefore, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use, and the incidence of untoward effects is dose related.
The usual dose is one tablet every six hours as needed for pain. (If necessary, this dose may be repeated at four-hour intervals.) In cases of more severe pain, two tablets every six hours (up to eight tablets in 24 hours) may be required.

Revised, April 1982. S68S

1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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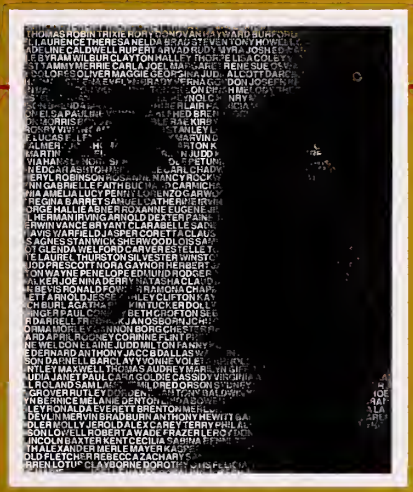

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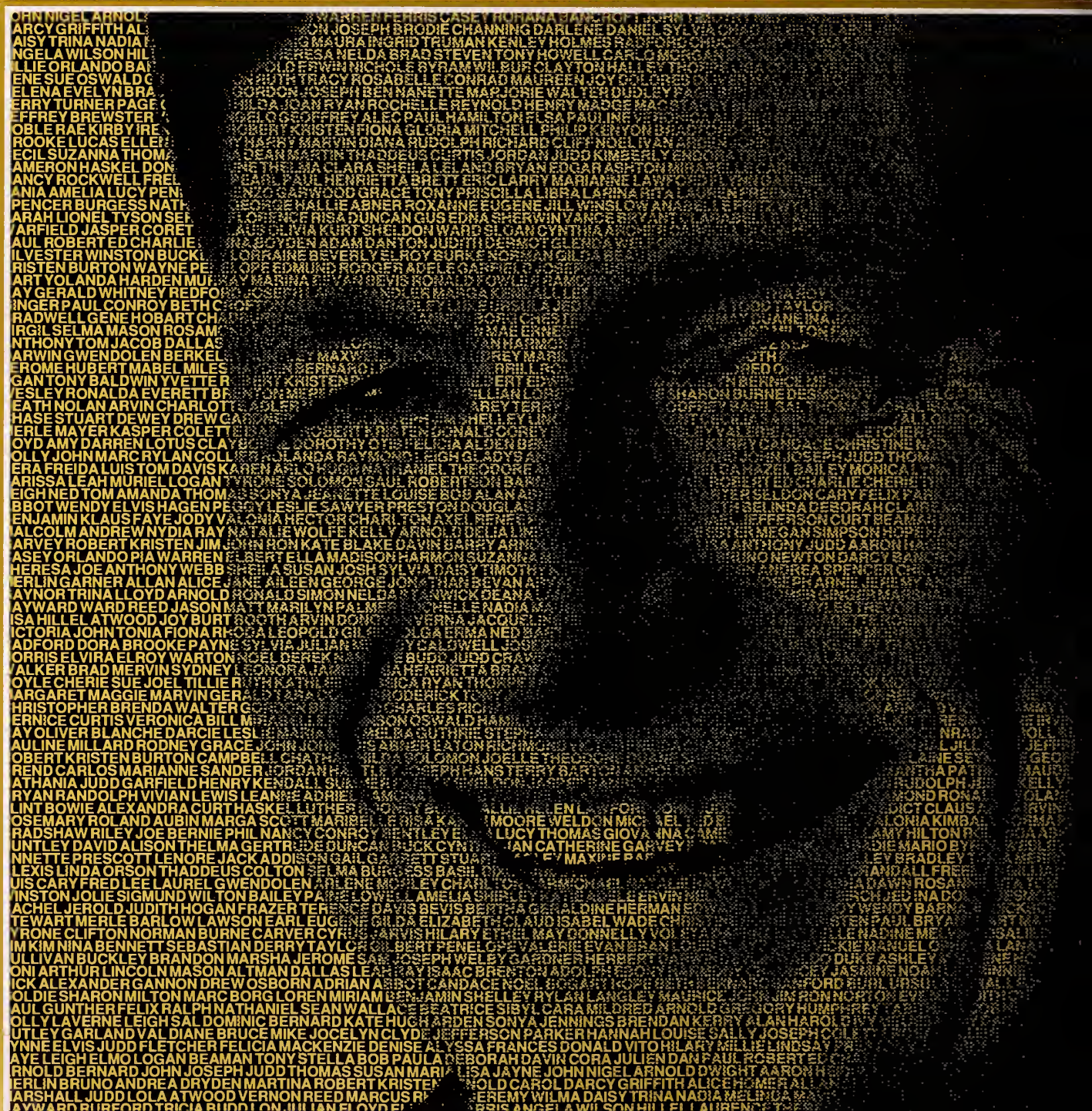

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...like the more than one million patients who have received INDERAL® LA.

In a recent survey, 4,120 participating physicians gave us their views[1] on INDERAL LA in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated INDERAL LA good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe INDERAL LA.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with INDERAL LA to be as good as, or better than, other beta blockers.

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

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INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES
60, 80, 120, 160 mg

The one you know best keeps looking better

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60 mg 80 mg 120 mg 160 mg

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295/188

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Helps angina patients get more out of life

Significantly reduces both the frequency of anginal attacks and the need for sublingual nitroglycerin[1]

Preferred by patients over 7 to 1 for convenience compared to their previous long-acting oral nitrate; only 12% had no preference (n = 4,300)[2]

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.
Please consult Brief Summary of Prescribing Information on the following page.

CIBA

© 1988, CIBA 629-5551-A

Transderm-Nitro® nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INOICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area.
Transderm-Nitro system should not be applied to the distal parts of the extremities.
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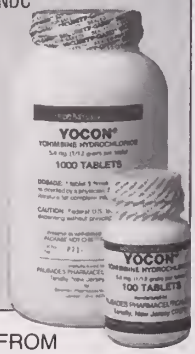

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Psychiatric Problems of a Rapidly Growing Retirement Region

Richard E. Gordon, M.D., Ph.D., and Katherine K. Gordon, M.A.

***ABSTRACT:** This paper retests the hypothesis that greater stress and a higher incidence of emotional disorder in the newcomer population accompany rapid community growth. Data on 2,067 psychiatric patients from four communities with different rates of growth showed that recent newcomers to fast-growing retirement communities were significantly more likely to become psychiatric outpatients.*

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Recently the joint Commission on Accreditation of Hospitals (JCAH) decided to use clinical outcome of treatment to measure quality of care. This decision reemphasizes the importance of assessing patient groups' special needs in treatment.

A series of studies in the late 1950s and early 1960s investigated the hypothesis that communities' "rapid growth, heterogeneous population, and relatively poor social integration . . . (are) . . . associated with social strains in (the socially mobile) patient groups."[1] Data showed that social mobility was highly associated with psychiatric and psychosomatic disorder, divorce, and delinquency. Young married women, new mothers in particular, and male children were most likely to require medical help for stress-related diseases.[2-8]

There is considerable literature on migration, mental illness, and community growth.[9-16] Most studies found that immigrants have higher rates of psychiatric illness than natives.[15,16] The present study examines whether the hypothesis also applies to rapidly-growing retirement communities on Florida's southwest coast.

This kind of community assessment of psychiatric patient groups' special characteristics, problems, and needs is important for planning psychiatric preventive and treatment programs. Previous studies led to development of effective programs for both treating and preventing psychiatric disorders among socially mobile new mothers. These helped women reduce perinatal stress, improve coping skills, develop mutual supports, and reduce psychiatric distress.[5-7] If data of the present study indicate that certain socially mobile groups are becoming especially distressed in the fast-growing areas, it may also be possible to design psychiatric preventive and treatment programs to help them.

Method ● We retrospectively analyzed current data from psychiatric outpatients who were treated in four communities: fast-growing Lee and Collier Counties and slowing-down Sarasota County in southwestern Florida's District 8, slow-growing Alachua County in north Florida, and stopped-growing Bergen County, New Jersey. Data were compared on newcomer status, defined as living in the community less than five years, age, diagnosis, marital status, and sex.

Florida's District 8 Health Planning Council provided data on psychiatric admissions to general and specialty hospitals in 1984. Community Mental Health Centers and private psychiatrists contributed data on patients currently in treatment in southwest Florida and Bergen County, New Jersey, in both the 1950s and 1980s eras.

The national census provided population, income and growth data. Significance of differences was calculated by chi-square (X^2). Patient data on diagnosis, age, sex, and marital status were considered reliable if there were no significant differences in these characteristics between the patients who visited each of two private psychiatrists or CMHCs in an area.

Statistical indicator data on death rates from suicides, cirrhosis, and automobile accidents in the rapidly growing southwest Florida area were obtained from the 1982 edition of Florida Vital Statistics[19] and the Bureau of the Census,[20] the latest year national data were available. These data provide a cross-validation of the findings with patients.

Lee County is presently growing at a rate of 6% a year and Collier County by 7.4%, almost entirely by immigration. Sarasota County grew rapidly from 1970 to 1980 (by 6.8%) but from 1980 to 1984 population increased by only 3.6% per year. Alachua County is presently growing at a rate of 2.8% per year. Bergen County, N.J., which grew at a rate of 7% per year in the 1950s, is now declining in population at a rate of about 0.6% per year.

Younger, less-educated adults, aged 18-44, are immigrating from other states to southwest Florida. They usually obtain low-paying jobs in nonunionized construction, sales, and service industries. As a rule they do not have health insurance policies. Adult immigrants, aged 45-64, are also generally employed in service and sales industries, but they are often better-educated professionals or businessmen who tend to have funds for psychiatric care or health insurance policies.

Results ● *Newcomer Status.* Disproportionately high percentages of newcomers are becoming psychiatric outpatients in every community. In the private practice sector of the District 8 area of southwest Florida, 53% of outpatients, and in the public Community Mental Health Centers, nearly the same number, 55%, had migrated there within the past four years. The percentage of newcomers among those who sought outpatient care in Bergen County, N.J., was still a high 24%. (Comparing numbers of psychiatric outpatient newcomers to expected numbers of newcomers from the community, $X^2 = 19.0$, $p < .001$). Since newcomers who have lived in the community for less than five years account for about 28% of the population in southwest Florida, the average percentage of newcomers among psychiatric outpatients (54%) nearly doubles their population percentage (28%).

Age of Outpatients. In the rapidly-growing retirement areas, adults aged 45 and older are more likely

Table 1.—Age of Outpatients.

	Private Outpatients				CMHC Outpatients
Location	Bergen County	Bergen County	Sarasota County	Collier County	District 8
Period	1950s	1980s	1980s	1980s	1980s
Growth Rate	7%	−0.6%	3.6%	7.4%	7%
Number of Pts.	975	345	105	173	469
Age		**Percent**			
under 17	23.5%	9%	10.5%	4.5%	23%
18-44	58	53	48.5	36.5	57.5
Subtotal	**81.5%**	**62%**	**59%**	**41%**	**80.5%**
45-59	14.5	29*	11.5	24.5	10
60-64	4**		5	13	6.5
65+		9	24.5	21.5	3
Subtotal	**18.5%**	**38%**	**41%**	**59%**	**19.5%**

*This percent includes all patients aged 45-64.
**This percent includes all patients aged 60 and older.

Table 2.—Diagnosis of Outpatients

	Private Outpatients			CMHC Outpatients
Location	Bergen County	Sarasota County	Collier County	District 8
Period	1980s	1980s	1980s	1980s
Growth Rate	−0.6%	3.6%	7.4%	7%
Number of Pts.	342	105	173	102
Diagnosis		**Percent**		
Major Depress*	11%	17%	18%	6%
Schizophrenia	12.5	33.5	9	6
Organic/Senille	1	15	7	2
Subtotal	**24.5%**	**65.5%**	**34%**	**14%**
Pers. Disorder	15%	1%	3%	6%
Alc./Subs. Abuse	6	6.5	2	
Neur. Depress.	13.5	16	49	21
Neurosis/Situat. Maladjust.	41	11	12	59
Substotal	**75.5%**	**34.5%**	**66%**	**86%**

*The category "Major Depression" includes patients with bipolar psychoses as well as others with psychotic depressions.

to seek outpatient treatment from private physicians than from public CMHCs. The mean percentage (57%) of patients in this age group seeking private psychiatric outpatient care exceeds the expected population percentage (42.8%) by 33%. The combined percentage (51%) of 45 years and older patients seeking outpatient psychiatric care in the rapidly-growing retirement area from both private psychiatrists and public CMHCs exceeds their population percentage (42.8%) by 19%, as well as the percentage of older outpatients in slower-growing Sarasota County (Table 1). However, there was no difference in the percentage of patients aged 45 and older whom each of two psychiatrists in the fast-growing retirement area treated (58.7% and 55%).

The percentage (80.5%) of patients aged 18 to 44 who go to CMHCs almost doubles the percentage (41%) who receive treatment from private psychiatrists ($X^2 = 42$, $p < .001$) and exceeds their expected population percentage (57.2%) by 41% ($X^2 = 59.8$, $p < .001$). These findings are similar to those of Bergen County in the 1950s when it was a rapidly-growing suburb.

Presently in Bergen County, the majority (83%) of newcomers among psychiatric outpatients are adults aged 18-44, similar to the 1950s when it was a fast-growing suburb.

The outpatient percentage of the aged 65 and older group was not greater than their population numbers in Lee and Collier Counties. However, among 1,801 inpatients admitted to the area's psychiatric and substance abuse wards of general and specialty hospitals, 26.9% were aged 65 and older (population percentage — 22.3%). The percentage of these inpatients exceeded their population percentage by 21%. Alcoholics and other substance abusers accounted for 43.7% of the older patients in the rapidly-growing areas.

The percentage (15.5%) of children in the rapidly growing retirement communities' CMHCs was greater than that in any of the private general psychiatrists' offices, but less than their population percentage (22.6%).

Income. Some of southwest Florida's fairly affluent people own both out-of-state and Florida homes and usually have health insurance and Medicare. They may obtain private psychiatric care in the area or go out of state, thus, larger percentages may be receiving psychiatric care than are shown here.

CMHC outpatients are generally low-income persons. About 16% have annual incomes of $15,600 or more. The percentage has been rising since 1978 when only 7% earned this amount.

Diagnosis. The most common diagnosis for patients treated by private psychiatrists in the rapidly growing retirement communities was neurotic depression. Although the two psychiatrists in the community diagnosed a significantly different percentage of their patients as being neurotically depressed (58% versus 44%), each percentage approximately tripled the percentage of diagnosed neurotic depression among psychiatric outpatients in the slower-growing

communities (13.5% in Bergen County and 16% in Sarasota County, Table 2).

Most outpatients in CMHCs in the fast-growing area were suffering from other neuroses or situational maladjustments. Private psychiatrists tended more than CMHCs to treat patients with psychosis, although there was no significant difference in the percentage of these patients seen by each of the two psychiatrists in the fast-growing retirement community (35% and 33%).

Statistical indicators ● These tended to confirm diagnostic findings. The suicide rate per 100,000 in 1982 was high in rapidly-growing District 8 (18.0) as compared to the rest of the nation (11.6), reflecting the findings on psychiatric depression in the region. The death rate from cirrhosis is high in District 8 (17.4), as compared to the U.S. (10.5), related to the high consumption of alcohol in the area. The motor vehicle fatality rate is high (30.9), as compared to the rest of Florida (26.5) and the nation (19.3). This rate is related in part to overcrowded roads, high alcohol and drug abuse problems, and the percentage of older people.

Sex of outpatients ● Women were more likely to seek outpatient help in the rapidly-growing retirement communities of the 1980s, as they were in the rapidly-growing suburbs of the 1950s (Table 3). The combined percentage of adult female psychiatric patients in the outpatient treatment settings of the fast-growing retirement communities (64.5%) exceeded the percentage in the population (51.6%) by 25%. There was no significant difference in the sex of outpatients — 65.9% and 61.3% females — in the practices of the two private psychiatrists in the fast-growing retirement area. Among inpatients, the sex difference in rapidly growing Collier County was much less; 50.3% of psychiatric inpatients were female.

The percentage of boys coming for help in the 1980s in every setting was not nearly so great as it was in the fast-growing suburbs of the 1950s.

Marital status ● Married persons are the most likely group to seek outpatient psychiatric help in today's rapidly-growing retirement communities, as occurred in the rapidly-growing suburbs of the 1950s. The combined percentage (63.7%) of married outpatients seeking help from both private psychiatrists and CMHCs is greater than in slower-growing communities and is similar to that of rapidly-growing Bergen County in the 1950s (80%). There was no significant difference in percentages of married patients seeking help from two psychiatrists in the rapidly-growing area (65.5% and 72%).

Increasing numbers of divorced and separated patients are now appearing in all the outpatient settings. Further, in the rapidly-growing area, 69.5% of the mothers of CMHC child outpatients were divorced or remarried (Table 4). In Bergen County in the 1950s, divorced or separated persons rarely sought psychiatric care as outpatients in their own behalf, although they accounted for 7.5% of inpatients (1950s population percentage — 2.4%).[2] Now 16% of outpatients in Bergen County are separated or divorced (population percentage 6%), while the percentage of married people has declined from 80% to 43.5% (current population percentage — 59%)

Nearly half (49%) of the CMHCs' child psychiatric outpatients have a single parent, usually a low-income mother. In the 1950s, 17% of boy outpatients and 10% of girl outpatients were brought to treatment by separated or divorced mothers.[3]

Discussion ● A number of explanations have been offered for findings of increased emotional distress among migrants. First, newcomers in a community often have left behind their extended social support networks and, thus, may be more vulnerable. Some younger retirees, military veterans in particular, may find it difficult to adjust to a loss of status and become discontented and bored with a routine of fishing and golfing. Others, the divorced and separated, for example, may have had difficulties in adjusting in the communities from which they migrated and, thus, may

Table 3.—Sex of Outpatients.

	Private Outpatients				CMHC Outpatients
Location	Bergen County	Bergen County	Sarasota County	Collier County	District 8
Period	1950s	1980s	1980s	1980s	1980s
Growth Rate	7%	−0.6%	3.6%	7.4%	7%
Number of Adult Patients	746	314	91	166	51
		Percent			
Female Adult	59%	53%	54%	62.5%	70.5%
Number of Child Patients	229	31			51
		Percent			
Female Children	25.5%	45%			43%

Table 4.—Marital Status of Outpatients.

	Adult Private Outpatients				CMHC Outpatients	
Location	Bergen County	Bergen County	Sarasota County	Collier County	District 8	
					Adults	Children
Period	1950s	1980s	1980s	1980s	1980s	1980s
Growth Rate	7%	−0.6%	3.6%	7.4%	7%	7%
Number of Pts.	746	314	101	163	51	51
Marital Status		Percent				
Widowed	<1%	6.5%	10%	7.5%	2%	2*%
Single	20	34	30	12.5	29.5	0
Sep./Div.	< 1	16	7	12.5	25	49**
Married	80	43.5	43	67.5	43	49†

* This child patient was living with grandparents.

** Two were living with their divorced father, the remainder were with their mother.

† Twenty-eight and a half percent of the parents were continuously married and 20.5% were remarried.

bring problems with them. But as a rule this is not true of Florida's older immigrants. Elderly retired people who move to Florida tend to be a healthy, well-adjusted lot.[17,18]

Managing the problems ● If these findings are confirmed by later research, they should be considered in formulating plans for increasing private and public psychiatric beds and for funding community mental health centers. To demonstrate high quality care and meet new JCAH standards, psychiatric treatment programs in fast-growing communities will need to address the special needs of recent immigrants. For example, social work services cannot be provided easily when there are no families nearby and other community resources are overburdened with the care of other distressed newcomers.

Summary ● This study shows that newcomers in a community accounted for more than half the psychiatric outpatients in the fast-growing retirement areas and for nearly one quarter of private outpatients in the county which had stopped growing. In the rapidly-growing communities, persons aged 45 years and older, especially married women, and younger divorced mothers with their children were seeking psychiatric outpatient treatment more than other groups. These outpatients were likely to be suffering from neurotic depressions, situational maladjustments, and other neuroses. Statistical indicator data on deaths from suicide, cirrhosis, and vehicular accidents tended to support the outpatient findings. The pattern of patients has changed in Bergen County, N.J., which has stopped growing. Single, divorced, and widowed persons of both sexes now make up the bulk of outpatient private psychiatric practice in this suburban area. Younger persons, aged 18-44, accounted for 83% of immigrant psychiatric outpatients there, as they also had in the period of rapid growth.

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References

1. Gordon, R.E. and Gordon, K.K.: Psychiatric Problems of Rapidly Growing Suburb, Arch, Neurol. Psychiat. 79:543-548, 1958.
2. Gordon R.E. and Gordon, K.K.: Social Psychiatry of Mobile Suburb, Int. Soc. Psychiat. 6:90-100, 1960.
3. Gordon, R.E. and Gordon, K.K.: Emotional Problems of Children in Rapidly Growing Suburb, Int. J. Social Psychiat. 4:85-97, 1958.
4. Gordon, R.E. and Gordon, K.K.: Psychosomatic Problems of Rapidly Growing Suburb, JAMA 170:1759-1764, 1959.
5. Gordon, R.E.: Sociodynamics and Psychotherapy, Arch. Neurol. Psychiat. 81:486-503, 1959.
6. Gordon, R.E.; Singer, M.G., and Gordon, K.K.: Social Psychological Stress, Arch. Gen. Psychiat. 4:459-470, 1961.
7. Gordon, R.E.; Gordon, K K., and Gunther, M.: Split-Level Trap, B. Geis Associated, New York, 1961.
8. Gordon, R.E. and Gordon, K.K.: Psychiatric Challenges of 1960s, Int. J. Soc. Psychiat. 10:223-231, 1964.
9. Jarvis, E.: Report on Insanity and Idiocy in Massachusetts, by the Commission on Lunacy, under Resolve of the Legislature, Boston, William White, Printer to the State, 1855.
10. Odegaard, O.: Emigration and Insanity: Study of Norwegianborn Population of Minnesota, Copenhagen, Levin & Munksgaards, 1932.
11. Malzberg, B. and Lee, E.S.: Migration and Mental Disease, Study of First Admissions to Hospital for Mental Disease, New York, Social Science Research Council, 1956.
12. Eitinger, L.: Mental Diseases Among Refugees in Norway after World War II. In: Zwingmann CA, and Pfister-Ammende M. (eds.): Uprooting and After, New York, Springer-Verlag, 1973.

13. Hollingshead, A.B. and Redlich, F.C.: Social Class and Mental Illness, Community Study, New York, John Wiley & Sons, 1958.
14. Lazarus, J.; Locke, B.Z., and Thomas, D.S.: Migration Differentials in Mental Disease, Milbank Mem. Fund Q.41:25-42, 1963.
15. Murphy, H.B.M.: Migration and Major Mental Disorders, Reappraisal. In: Kanter, M.D. (ed.): Mobility and Mental Health, Springfield, ILL., Charles C. Thomas, 1965.
16. Schwab, J.J.; Bell, R.A.; Warheit, G.J., and Schwab, R.B.: Social Order and Mental Health, Florida Health Study, Brunner/Mazel, New York, 1979.
17. Longino, C.F., el al: Retirement Migration Project: Final Report for National Institute on Aging, Center for Social Research in Aging, Coral Gables, University of Miami, 1984
18. Longino, C.F. and Corcoran, E.H : Statistical Profile of Older Floridians, for State and Agency Planners, Center for Social Research in Aging, Coral Gables, University of Miami, 1983.
19. Department of Health and Rehabilitative Services, Florida Vitla Statistics, 1982, P.O. Box 210, Jacksonville.
20. U.S. Bureau of the Census: 1986 (106th Edition), Washington, D.C., 1985.

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Surgeon's Acute Carpal Tunnel Syndrome: An Occupational Hazard?

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***ABSTRACT:** A case is reported of an acute carpal tunnel syndrome. The condition occurred in a surgeon's nondominant hand during a lengthy, difficult operative procedure.*

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The pathological and clinical descriptions of carpal tunnel syndrome originated over 70 years ago.[1,2] For the most part, contemporary awareness is attributed to the efforts of Phalen.[3,4] Continuing medical education has brought the condition to the attention of primary care physicians and subspecialists as well as the general public. In most cases, symptoms once attributed to "poor circulation" prompt referral to appropriate sources for diagnostic and/or therapeutic endeavors directed toward the median nerve in the proximal palm.

The medical literature more than adequately covers the syndromes' frequency, etiologies and treatments. Acute carpal tunnel syndrome is less common than the chronic variety and is usually related to local trauma and its treatments and rapidly progressing inflammatory conditions.[5-8] Pregnancy and hemorrhage that is either spontaneous or associated with anticoagulant therapy also may precipitate symptoms.[9,10] More chronic presentations are usually related to inactivity and influenced by active or passive wrist flexion which compromises the nerve's integrity within the carpal canal. Prolonged wrist flexion should also be considered in the differential diagnosis of acute median nerve compression syndroms.

Case report ● A 47-year-old general surgeon noted numbness and tingling in the left hand associated with clumsiness of the thumb. The symptoms appeared spontaneously three days previously during a lengthy abdominal operation when intraoperative complications necessitated using a fully flexed left wrist to retract the bowel to access the biliary system. The procedure lasted eight hours. The symptoms were associated with the inability to bring the thumbs out of the palm. Past history failed to obtain previous symptoms of a similar nature. There was no diabete

nor other diseases associated with increased sensitivity or peripheral nerves to ischemia/hypoxia.

Physical examination showed normal wrist and finger motion. Thumb abduction and opposition were absent (Fig.1). There was diminished sensibility over the pulps of the thumbs and index finger; two point discrimination was increased (6-8 mm) in the same area. Normal neurological findings were recorded for the middle, ring and small fingers. A moderately painful paraesthesia was obtained when tapping over the distal wrist crease. Neither swelling nor discoloration was noted in the palm or wrist. Long flexor muscle power was normal. The cervical spine moved normally and DTR were equal bilaterally. Both radial and ulna pulses were strong.

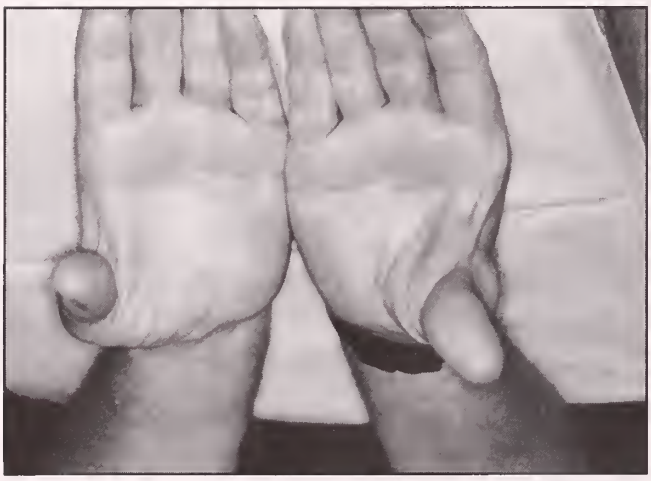

Fig. 1.—Both hands during active abduction of the thumbs. The left thumb cannot be brought out of the plane of the palm.

Radiograms showed traumatic arthritis at the 1st carpometacarpal joint.

A diagnosis of acute carpal tunnel syndrome was made. The patient was treated in a volar wrist extension splint and a homebound exercise program; vitamin B6 100 mg daily was ordered. The patient responded well and noted improved sensation by the second week. Full abductor muscle power returned in six weeks at which time sensibility of the thumb and index was normal. One year postinjury, no recurrences of symptoms have been observed.

Comment • Many surgeons have experienced numbness and tingling in the fingers during operative procedures and usually attribute the discomfort to the constricting effect of surgical gloves, rarely is the median nerve considered as the source. Carpal tunnel syndrome, the symptoms of which may be many and varied, is probably more often the cause of such symptoms than generally realized.

References

1. Paget J. Lectures on Surgical Phathology, ed. 2, Philadelphia, Lindsay and Blakiston, 1854, p.42.
2. Marie, P. and Foix, C.: Atrophie isolee de l'eminence thenar d'origine nevritique Role du Ligament annulaire anterieur de carpe dans la pathogenie de la lesion Rev. Neurol. 26:647-649, 1913.
3. Phalen, G.S.: Carpal Tunnel Syndrome, Seventeen Years Experience in Diagnosis and Treatment of Six Hundred Fifty Four Hands, J. Bone Joint Surg. 48A: 211-228, 1966.
4. Phalen, G.S.: Reflection on 21 Years' Experience with Carpal Tunnel Syndrome, JAMA, 212: 1365-1367, 1970.
5. Adamson, J.E., Srouji, S.J.; Horton, C.E., and Mladick, R.A., acute Carpal Tunnel Syndrome, Plas. Reconstr. Surg. 47:332-336, 1971.
6. Bailey, D. and Bolton, C.J.F.: Median Nerve Palsy Associated with Acute Infection of Hand, Lancet, 1:530-532, 1955.
7. Kinley, D.L. and Evarts, C.M.: Carpal Tunnel Syndrome Due to Small Displaced Fragment of Bone, Cleveland Clin. Quart. 35:215-221, 1968.
8. Lynch, A.C. and Lipscomb, P.R.: Carpal Tunnel and Colles Fracture, JAMA 185:363-366, 1963.
9. Hartwell Jr., S.W. and Kurtay, M.: Carpal Tunnel Compression Caused by Hematoma Associated with Anticoagulant Therapy, Cleveland Clin. Quart, 33:127-129, 1966.
10. Hayden, J.W.: Median Neuropathy in Carpal Tunnel Caused by Spontaneous Intraneural Hemorrhage, J. Bone Joint Surg. 46A:1242-1244, 1964

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MRI of the Testicle: Preliminary Observations

Stephen F. Quinn, M.D., William Jones, M.D., John Knochel, M.D., Courtney Cochran, R.T., and Robert A. Clark, M.D.

***ABSTRACT:* This is a report on our early experience of imaging testicles with MRI at 1.5 Tesla. Initially the body coil was used for imaging but because of improved resolution surface coils were subsequently used. Heavily T-2 weighted images (TR 2000 msec; TE 90 msec) best differentiated normal testicular tissue from inflammatory and neoplastic tissues. The inflammatory and neoplastic processes were both hypointense relative to normal testicular tissue. MRI defines the fascial planes of the scrotum which may prove to be an advantage over sonography. Evaluation of undescended testicles using T1 weighted images (TR 600 msec, TE 25 msec) may prove to be useful primarily because of its ability to visualize the spermatic cord.**

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Evaluation of the testicles has traditionally involved clinical findings, sonography,[1-4] and scintigraphy.[5] For imaging of undescended testicles, sonography[6] as well as computed tomography,[7] and angiography[8] have been used. There have been several articles discussing the MRI findings of the male pelvis which were done at .35 and .5-T without surface coil technique.[9-10] The delineation of intrascrotal anatomy was limited in these reports. Subsequent reports from multiple institutions described preliminary findings of normal and abnormal testicles and scrotal contents using surface coil technique.[11-15] We report our early experience imaging the testicle with MRI at 1.5 Tesla, with an emphasis on surface coil technique.

Materials and methods ● A 1.5-T superconductive MR unit (Signa; General Electric Corp., Milwaukee) was used to study ten patients. Seven patients had suspected intrascrotal abnormalities, one a suspected penile mass, one a suspected penile hematoma and one an undescended testicle. The initial three patients were imaged using the body coil. No special technique was used to position the scrotum in these cases.

The later seven patients were imaged using a 5 in circular receive only surface coil. The patient was supine with the legs positioned together and the scrotum elevated by a towel. The surface coil was placed over the evaluated scrotum.

A 256 x 256 pixel matrix with a field of view of 16 cm was used. For patients with the instrascrotal abnormalities, a repetition time (TR) of 2000 msec and echo times (TE) of 25 msec and 90 msec were used. For the patient with an undescended testicle, a TR of 600 msec and TE of 25 msec were selected. Two excitations and 5 mm thick sections with 1 mm intersection gaps were used. The imaging time was approximately 17 minutes. Coronal images for the intrascrotal abnormalities, and coronal and axial

images for the undescended testicle were used.

Results ● Two of the patients in an early portion of the study had hydroceles. The fluid was of intermediate signal on the spin density images (SE 2000/25) and of increased intensity on the T-2 weighted (T2WI)(SE 2000/90) images. The third patient in this group had no discernable testicular abnormalities. None of these patients had surgical verification.

Because the resolution and soft tissue contrast were poor with the first three patients using the body coil, the latter seven patients were imaged with surface coil technique. One of these patients had a seminoma. The spin density image (SE 200/25) of this patient was less helpful than the more T2WI (SE 2000/90) in differentiating tumor from normal testicle. The tumor was less intense than normal testicular tissue (Fig. 1). It was easier to delineate with MRI than at gross pathology. There was a small amount of fluid between the parietal and visceral layers of the tunica vaginalis. The layers of the tunica vaginalis, tunica albuginea, internal and external spermatic fascia, and cremasteric fascia were all hypointense. They were best defined on the T2WI and except where fluid was present could not be separated as individual layers. The other exception to this being between the epididymis and testicle where the tunica albuginea is seen separately. The epididymis on the ipsilateral side was compressed and followed the signal intensity of the normal testicular parenchyma. The contralateral epididymis was enlarged and showed an area of diminished signal on the T2WI (SE 2000/90) within it. Normal testicular tissue becomes more intense with T2WI.

Three patients had epididymoorchitis. There was enlargement of the testicle and epididymis with areas of diminished signal corresponding to regions of orchitis which was consistent with the clinical and surgical findings. Fluid between the layers of the

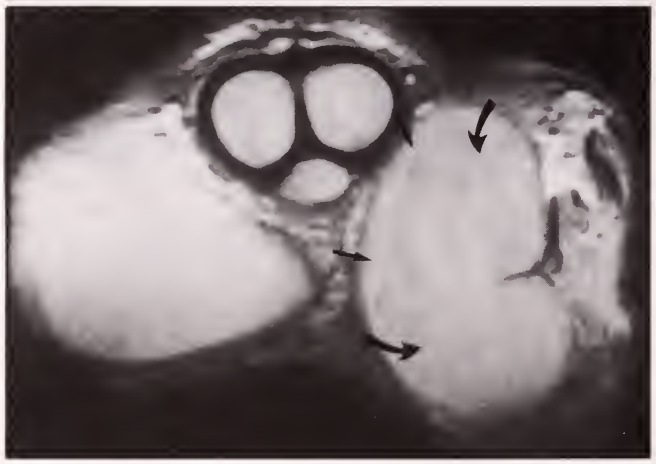

Fig. 1a

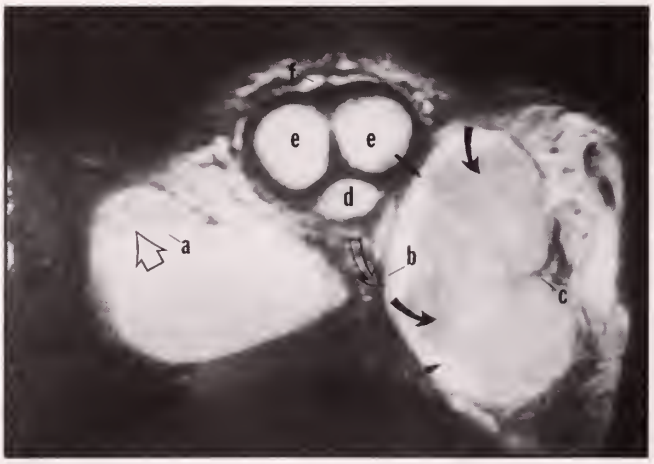

Fig. 1b

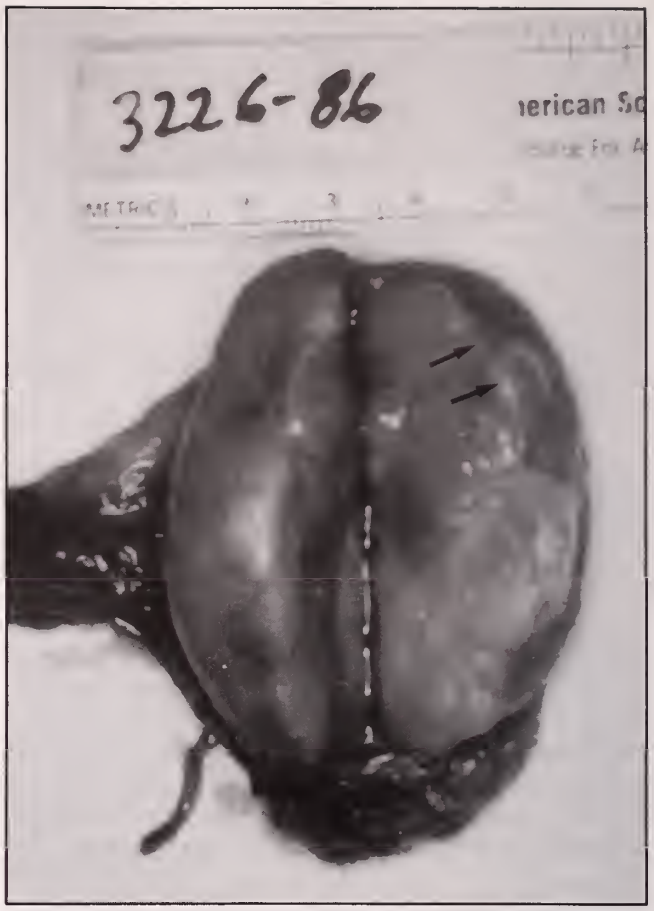

Fig. 1c

Fig. 1.— Seminoma.
1a.: The spin density (SE 2000/25) image shows relatively little contrast discrimination between normal testicular tissue (arrows) and tumor (curved arrows).
1b: The T-2 weighted image (SE 2000/90) shows the relatively hypointense tumor (curved arrows), compressing a rim of higher intensity normal parenchyma (arrows). There is a small fluid collection (open curved arrows) and an enlarged, complex contralateral epididymis (open arrow). a: Tunica albuginea; b: Visceral layer of tunica vaginalis and tunica albuginea; c: Mediastinum; d: Corpus spongiosum; e: Corpus cavernosum; f: Deep dorsal vein. 1c: The pathologic specimen shows only a thin rim of normal testicular parenchyma could be identified (arrows). This was better seen with MRI.

Fig. 2a

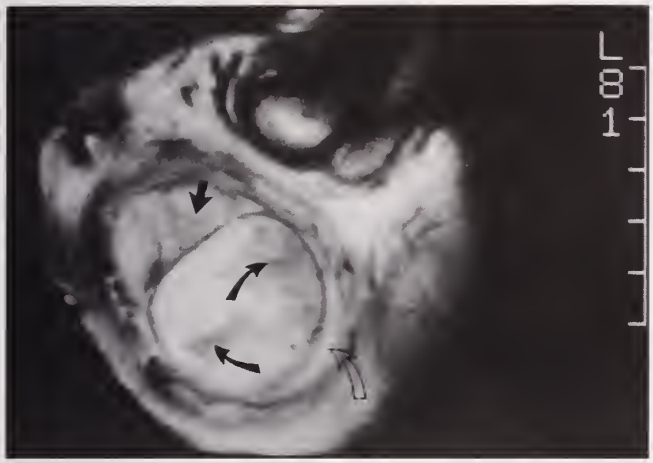

Fig. 2b

Fig. 2.—Epididymoorchitis.
2a: The spin density (SE 2000/20) image shows an enlarged epididymis (arrows) and testicle (curved arrow). There is a surgical drain in place (open arrow). 2b: The T-2 weighted (SE 2000/20) image demonstrates areas of inflammation within the epididymis (arrow) and testicle (curved arrows) which are hypointense. There is fluid present (open curved arrow) between the visceral and parietal layers of the tunica vaginalis.

tunica vaginalis could be identified (Fig. 2). The more T2WI (SE 2000/90) best discriminated the areas of abnormalities within the scrotum. The abnormal epididymis had heterogenous increased signal on T2WI.

One patient was a male with leukemia who had an MRI examination prior to testicular biopsy as part of a treatment protocol. The MRI was normal as was the surgical biopsy.

One patient with penile trauma had two high signal collections in the base of the penis on T-1 weighted image (T1WI) and T2WI consistent with hematomas. The scrotal contents were normal.

The one patient with an undescended right testicle showed good anatomical detail despite the patient crying during the examination. The images showed in detail the normal left testicle and spermatic bundle (Fig. 3). The right inguinal canal showed no evidence of a testicle but did show hypointense linear structures, the significance of which are uncertain but may represent a normal inguinal neurovascular bundle. They did not have the expected course of the spermatic cord. At surgery, there was complete agenesis of the right gonadal system.

Fig. 3a

Fig. 3b

Fig. 3.—Agenesis of right testicle.
3a: The coronal image (TR 600 TE 25) demonstrates a normal left testicle (arrow) and a small hydrocele (curved arrow). a: Femoral vessels; b: Inguinal lymph nodes. 3b: A more anterior section shows the course of the normal left spermatic cord (arrows). The linear hypointense structures on the right (curved arrows) do not have the expected course of the spermatic cord and may represent an inguinal neurovascular bundle. b: Lymph nodes.

Discussion ● The examination of the testicle for mass lesions, complex inflammatory processes, and for the undescended testicle within the inguinal canal is clearly within the domain of high resolution

sonography.[6] There is an extensive experience with sonography and it is inexpensive, fast, accurate and readily available and nonionizing. MRI, besides being in its infancy, suffers from unavailability, patient motion, and high cost. It would seem imprudent, however, to dismiss it so early in its development.

Although the number of patients in this report is limited, some applicable information was acquired. T2WI sequences are the best for depicting both normal and abnormal findings. Presumably because of the relatively prolonged T-2 relaxation time of normal testicles, abnormalities tend to be hypointense. The exception is extratesticular fluid collections.

Our early experience with body coil imaging was quickly forsaken in favor of surface coil technique. The improved resolution allowed confident identification of anatomical structures. The ability to image the layers surrounding the testicle has significant implications. For example, this could be helpful in determining testicular capsular integrity after trauma or during tumor staging. Currently, MRI is the only noninvasive method of imaging fascial layers surrounding the testicle.

Patients with undescending testicles are usually initially evaluated with sonography because most are within the inguinal canal.[16] The undescended testicle will appear as a nonspecific hypoechoic structure, an appearance indistinguishable from an inguinal lymph node.[6] With CT, the undescended testicle is isodense with lymph nodes and unopacified loops of bowels.[7] MRI, however, visualizes the spermatic cord as it traverses the inguinal canal allowing the path of testicular descension to be examined. This is aided by the ability to image in the coronal plane. It is known that in some situations, components of the spermatic cord will extend more caudal than the testicle.[7] Even so, this capability should enhance the degree of confidence in establishing the status of the undescended testicle. The T1 and T2 relaxation values of undescended testicles versus lymph nodes will have to be examined as will the feasibility of intra-abdominal imaging. Our experience is consistent with the work of others.[15]

Inflammatory changes of epididymis caused increased signal on T2WI. Normally, the epididymis has a lower signal than the testicle on both T1WI and T2WI.[11,13,14]

In summary, our early experience with testicular MRI with surface coil technique has shown that it can clearly define testicular abnormalities and unlike sonography define fascial planes within the scrotum. The signal intensity from inflammatory and neoplastic processes are both diminished relative to normal testicular tissue on T2 weighted images. It may also be helpful in the evaluation of undescended testicles primarily because of the definition of the spermatic cord.

Acknowledgment

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References

1. Grantham, J.G.; Carboneau, J.W.; James, E.M., et al: Testicular Neoplasms 29 Tumors Studied by High-Resolution Ultrasound, Radiology 157:775-780, 1985.
2. Vick, C.W.; Bird, K.I.; Rosenfield, A.T., Richter, J., and Taylor, K.J.: Ultrasound of Scrotal Contents, Urol. Radiol 4:147-153, 1982.
3. Hricak, H. and Filly, R.A.: Sonography of Scrotum, Invest. Radiol. 18:112-121, 1983.
4. Arger, P.H.; Mulhern, C.B.; Coleman, B.G. et al: Prospective Analysis of Value of Scrotal Ultrasound, Radiology 141:763-766, 1981.
5. Holder, L.E.; Melloul, M., and Chen, D.: Current Status of Radionuclide Scrotal Imaging, Semin. Nucl. Med 11:232-249, 1981
6. Madrazo, B.L.; Klugo, R.C.; Parus, J.A., and DiLoreto, R.: Ultrasonographic Demonstration of Undescended Testes, Radiology 133:181-183, 1979.
7. Lee, J.K.; McClennan, B.L.; Stanley, R.J., and Sagel, S.S.: Utility of Computed Tomography in Localization of Undescended Testis, Radiology 135:121-125, 1980.
8. Jacobs, J.B.: Selective Gonadal Venography, Radiology 92:885-888, 1969.
9. Hricak, H.; Williams, R.D.; Spring, D.B., et al: Anatomy and Pathology of Male Pelvis by Magnetic Resonance Imaging, AJR 141:1101-1110, 1983.
10. McClure, R.D. and Hricak, H.: Magnetic Resonance Imaging: Its Application to Male Infertility, Urology 27:91-98, 1986.
11. Seidenwurm, D.; Smathers, R.L.; Lo, R.K., et al: Testes and Scrotum: MR Imaging at 1.5T, Radiology 164:393-398, 1987.
12. Baker, L.L.; Hajek, P.C.; Burkhard, T.K., et al: MR Imaging of Scrotum: Normal Anatomy, Radiology 163:89-92, 1987.
13. Baker, L.L.; Hajek, P.C., Burkhard, T.K., et al: MR Imaging of Scrotum: Pathologic Conditions, Radiology 163:93-98, 1987.
14. Rholl, K.S.; Lee, J.K.T.; Ling, D., et al: MR Imaging of Scrotum With High-Resolution Surface Coil, Radiology 163:99-103, 1987.
15. Fritzsche, P.J.; Hricak, H.; Kogan, B.A., et al: Undescended Testis. Value of MR Imaging, Radiology 164:169-173, 1987.
16. Smith, D.R.: Disorders of Testis, Scrotum and Spermatic Cord. In General Urology, Smith, D.R. (ed.), Lange Medical Publications, Los Altos, California, 1978 Chap. 30, pp. 464-475.

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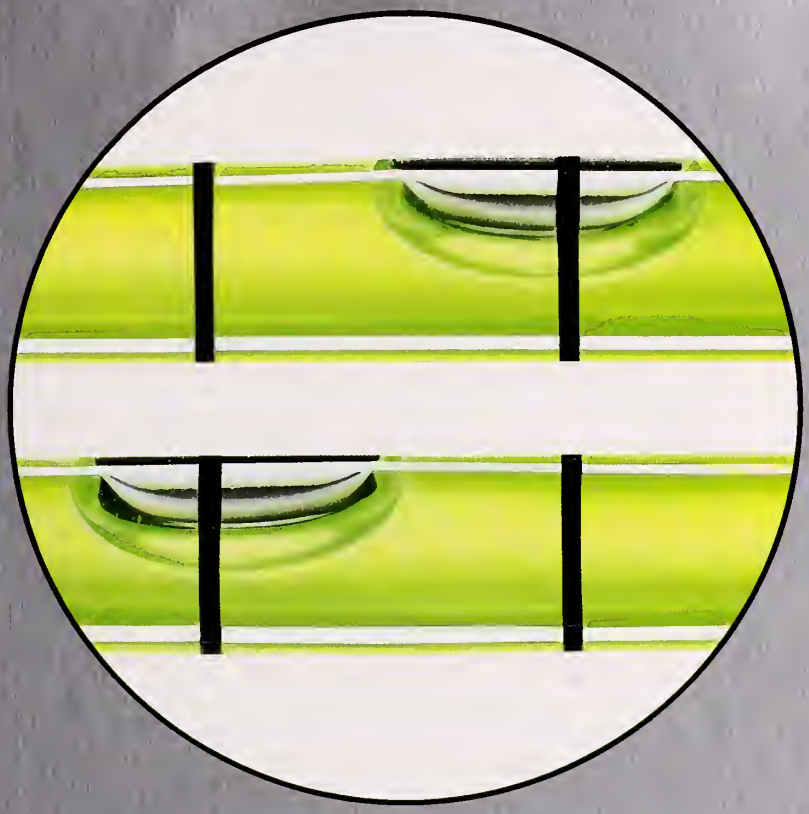

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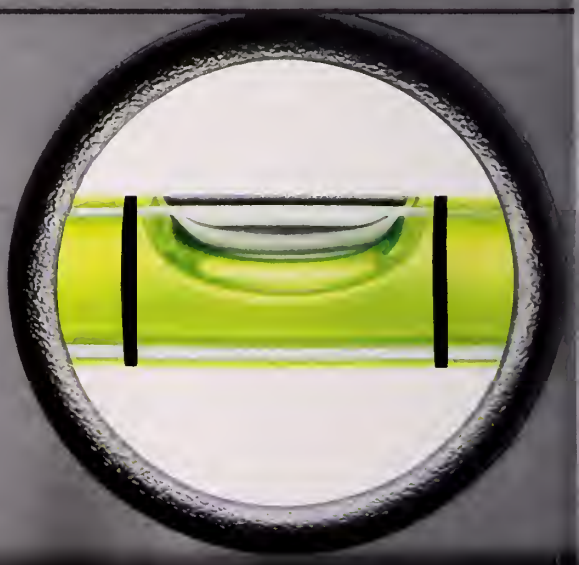

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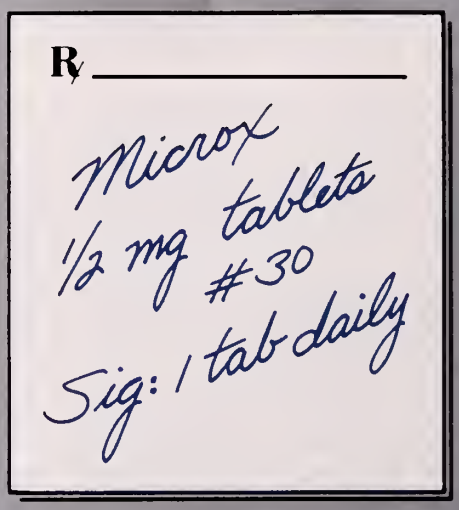
REFERENCES

1. Curry CL, Janda SM, Harris R, et al: Clinical studies of a new, low-dose formulation of metolazone for the treatment of hypertension. *Clin Ther* 1986;9:47-62.
2. Data on file, Pennwalt Prescription Division.



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DO NOT INTERCHANGE: MICROX® TABLETS ARE A RAPIDLY AVAILABLE FORMULATION OF METOLAZONE FOR ORAL ADMINISTRATION. MICROX TABLETS ARE NOT THERAPEUTICALLY EQUIVALENT TO ZAROXOLYN® TABLETS. FORMULATIONS BIOEQUIVALENT TO MICROX AND FORMULATIONS BIOEQUIVALENT TO ZAROXOLYN SHOULD NOT BE INTERCHANGED FOR ONE ANOTHER.

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MICROX TABLETS HAVE NOT BEEN EVALUATED FOR THE TREATMENT OF CONGESTIVE HEART FAILURE OR EDEMA DUE TO RENAL OR HEPATIC DISEASE. MICROX TABLETS SHOULD NOT BE USED WHEN DIURESIS IS DESIRED.

USAGE IN PREGNANCY The routine use of diuretics is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no evidence that they are useful in the treatment of developed toxemia. See PRECAUTIONS.

CONTRAINDICATIONS Anuria, hepatic coma or pre-coma, known allergy or hypersensitivity to metolazone.

WARNINGS Rarely, the rapid onset of severe hyponatremia and/or hypokalemia has been reported following initial doses of thiazide and non-thiazide diuretics. When symptoms consistent with electrolyte imbalance appear rapidly, drug should be discontinued and supportive measures should be initiated immediately. Parenteral electrolytes may be required. Appropriateness of therapy with this class of drug should be carefully re-evaluated. Hypokalemia may occur with consequent weakness, cramps, and cardiac dysrhythmias. Serum potassium should be determined at regular intervals, and dose reduction, potassium supplementation or addition of a potassium-sparing diuretic instituted whenever indicated. Hypokalemia is a particular hazard in patients who are digitalized or who have or have had a ventricular arrhythmia; dangerous or fatal arrhythmias may be precipitated. Hypokalemia is dose related.

In general, diuretics should not be given concomitantly with lithium because they reduce its renal clearance and add a high risk of lithium toxicity. Unusually large or prolonged losses of fluids and electrolytes may result when metolazone is administered concomitantly to patients receiving furosemide (see DRUG INTERACTIONS). When Microx Tablets are used with other antihypertensive drugs, particular care must be taken to avoid excessive reduction of blood pressure, especially during initial therapy. Cross-allergy, while not reported to date, theoretically may occur when Microx Tablets are given to patients known to be allergic to sulfonamide-derived drugs, thiazides, or quinethazone.

PRECAUTIONS Formulations bioequivalent to Microx and formulations bioequivalent to Zaroxolyn should not be interchanged for one another. All patients receiving therapy with Microx Tablets should have serum electrolyte measurements done at appropriate intervals and be observed for clinical signs of fluid and/or electrolyte imbalance: namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. In patients with severe edema accompanying cardiac failure or renal disease, a low-salt syndrome may be produced, especially with hot weather and a low-salt diet. Serum and electrolyte determinations are particularly important when the patient has protracted vomiting, severe diarrhea, or is receiving parenteral fluids. Warning signs of imbalance are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pain or cramps, muscle fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hyponatremia may occur at any time during long term therapy and, on rare occasions, may be life threatening. The risk of hypokalemia is increased when larger doses are used, when diuresis is rapid, when severe liver disease is present, when corticosteroids are given concomitantly, when oral intake is inadequate or when excess potassium is being lost extrarenally, such as with vomiting or diarrhea.

Metolazone may raise blood glucose concentrations possibly causing hyperglycemia and glycosuria in patients with diabetes or latent diabetes. Microx regularly causes an increase in serum uric acid and can occasionally precipitate gouty attacks even in patients without a prior history of them. Azotemia, presumably pre-renal azotemia, may be precipitated during the administration of Microx Tablets. If azotemia and oliguria worsen during treatment of patients with severe renal disease, Microx Tablets should be discontinued. Use caution when administering Microx Tablets to patients with severely impaired renal function. As most of the drug is excreted by the renal route, accumulation may occur. Orthostatic hypotension may occur, this may be potentiated by alcohol, barbiturates, narcotics, or concurrent therapy with other antihypertensive drugs. Hypercalcemia has been noted in a few patients treated with metolazone. Thiazide diuretics have exacerbated or activated systemic lupus erythematosus and this possibility should be considered with Microx Tablets.

DRUG INTERACTIONS Furosemide and probably other loop diuretics given concomitantly with metolazone can cause unusually large or prolonged losses of fluid and electrolytes (see WARNINGS). When Microx® (metolazone) Tablets are used with other antihypertensive drugs, care must be taken, especially during initial therapy. Dosage adjustments of other antihypertensives may be necessary. The hypotensive effects of alcohol, barbiturates, and narcotics may be potentiated by the volume contraction that may be associated with metolazone therapy. Diuretic-induced hypokalemia can increase the sensitivity of the myocardium to digitalis; serious arrhythmias can result. Corticosteroids or ACTH may increase the risk of hypokalemia and increase salt and water retention. Serum lithium levels may increase (see WARNINGS). Diuretic-induced hypokalemia may enhance neuromuscular blocking effects of curariform drugs, the most serious effect would be respiratory depression which could proceed to apnea. Accordingly, it may be advisable to discontinue Microx Tablets three days before elective surgery. Salicylates and other non-steroidal anti-inflammatory drugs may decrease the antihypertensive effects of Microx Tablets. Requirements for insulin and other antidiabetic agents may be altered during administration of Microx Tablets. Arterial responsiveness to norepinephrine may be decreased, but not sufficiently to preclude effectiveness of this pressor agent for therapeutic use. Efficacy of methenamine may be decreased due to urinary alkalizing effect of metolazone.

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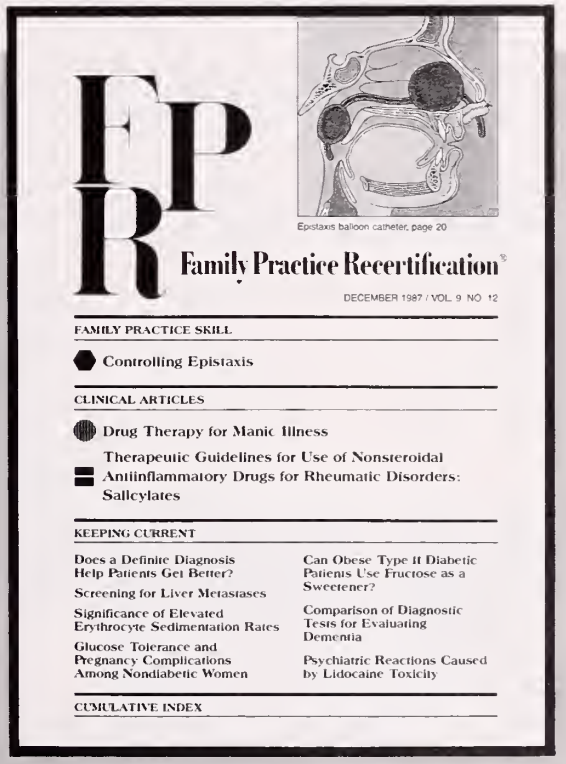

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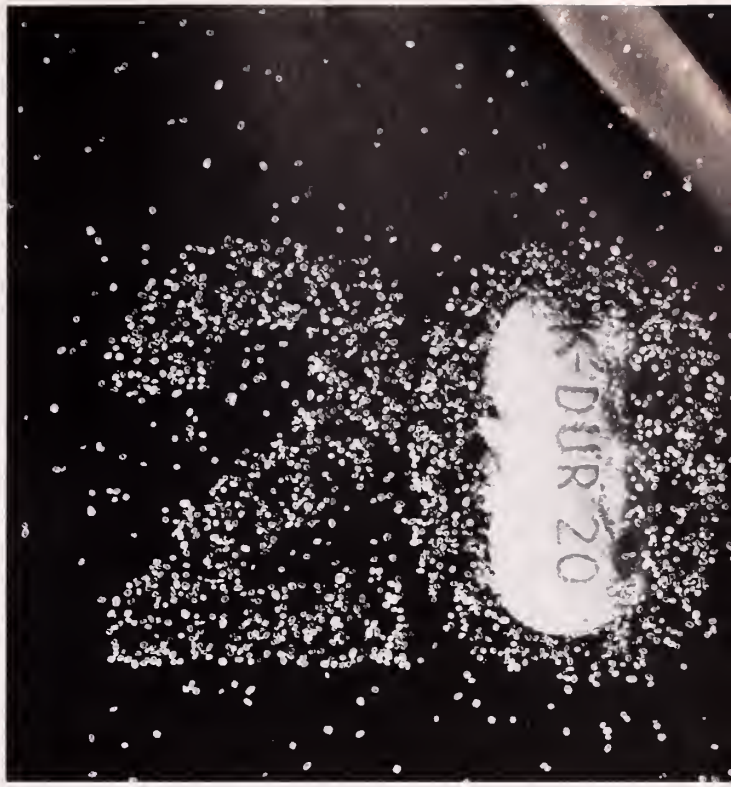

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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SPECIAL ARTICLE

Mandatory Risk Management in CME: Two Year's Experience

Robert C. Fore, Ed.D., Pierre J. Bouis Jr., M.D., and Joan M. Runnels

***ABSTRACT:* Florida physicians were directed by the Legislature in 1985 to begin earning five hours credit in risk management each biennium as a condition of relicensure. This article describes the provisions of the continuing medical education requirement, reports on efforts to assist physicians in adhering to the newly imposed mandate, and provides an overview of the malpractice crisis which has reached epidemic proportions.**

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"No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egotism of a most intense kind, to which there is no antidote. The few setbacks are forgotten, and mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction and abominably self-centered."

— Sir William Osler

At the new Johns Hopkins University School of Medicine around the turn of the century, the master clinician, Sir William Osler, could not have envisioned the current malpractice crisis which has reached epidemic proportions. He would have failed to foresee an environment which is driving dedicated practitioners out of the medical profession due to escalating professional liability premiums even though they may have never suffered a malpractice claim.

American Medical Association representatives testifying before Congress in 1986 on tort reform stated that malpractice claims were brought against physicians in 1984 at approximately three times the rate experienced in the 1970s. In 1984 the cost of medical professional liability was estimated between $11 billion and $13 billion. This cost generated by the liability problem was responsible for 14.5% to 17.5% of the $75.4 billion spent on physician services.[1]

According to Seligson, professional malpractice premiums in 1985 totaled more than $1 billion a year and added an estimated $5 a day to every patient's hospital bill and $3 to $4 to the cost of each office visit.[2] The litigious nature of society contributing to increased malpractice insurance premiums provoked the practice of defensive medicine by physicians, ultimately increasing the cost of health care.

An estimated 30% to 40% of all diagnostic procedures ordered by physicians are attributable to the

practice of defensive medicine.[3] Moreover, 70% of the nation's physicians have indicated an alteration in the way they practice to protect themselves against lawsuits.

Based on a study of closed claims filed with the Department of Insurance, State of Florida, injured patients received less than 30% of each dollar. According to 1986 statistics provided by the Florida Physicians Insurance Company, dollars paid out due to malpractice claims are distributed as follows: 31.5% to the injured party, approximately 21% to the plaintiff attorney, 18.4% to the defense attorney, 17.8% to administrative costs, and 11.3% to defense costs.

In a 1985 survey conducted by the American College of Obstetricians and Gynecologists, the average increase in malpractice premiums amounted to $9,871, with one out of four OB/GYNs experiencing increases by as much as $13,000.[4] The highest increases occurred in New York and Florida, $21,635 and $17,131 respectively, amounting to over 10% of the physician's gross income. Two thirds of all OB/GYNs reported increases in the use of diagnostic tests and the amount of time needed to document their activities in response to the threat of claims. This survey also revealed that economic pressures of malpractice claims have forced more than 12% of those surveyed to stop practicing.

The current malpractice situation in Florida has reached epidemic proportions; 95% of the neurosurgeons have been sued at least once. The frequency of claims for 100 insured physicians increased from 9.99 per 100 in 1976 to 35.42 per 100 in 1985.

A survey of Florida physicians revealed that, due to increased malpractice premiums from 1983 to 1986, $837 was attributed to every operation performed by a neurosurgeon in Volusia County (Daytona Beach), $102 per operation for a general surgeon in Dade County (Miami), $20 for each office visit to an OB/GYN or neurosurgeon and $249 for the delivery of each baby.[5]

If frequency of claims served as the basis of a needs assessment for continuing medical education activities, the following St. Paul Insurance Company data would be useful:[6]

1.	Surgery/postoperative complications	1,760
2.	Improper treatment/birth related	804
3.	Failure to diagnose/cancer	631
4.	Surgery/inadvertent act	571
5.	Failure to diagnose/fracture-dislocation	452
6.	Improper treatment/drug side effect	425
7.	Surgery/inappropriate procedure	414
8.	Failure to diagnose/pregnancy problems	364
9.	Improper treatment/fracture-dislocation	344
10.	Failure to diagnose/infection	300

Such data apparently caused the majority of legislators to believe that the cause of the malpractice crisis is indeed malpractice. If the crisis is caused solely by malpractice on the part of physicians, then common sense would dictate that continuing medical education activities would help to reduce the problem.

The president of the Hillsborough County Medical Association who practices in Tampa recently stated that ". . . if bad doctors were the problem, the paradoxes literally cry out for answers."[7]

Why is medical care getting better by every index, while the number of suits goes up?

Why are there more "bad doctors" in Florida than in Indiana, for instance?

Why are there more suits in the specialties that require some of the longest and most intensive training, such as plastic surgery, neurosurgery, cardiac surgery, and obstetrics?

Why does America have the worst doctors in the world as indicated by the number of suits, yet the best health care?

Why is it that the best students enter medicine and then turn out to be the least competent?

Doesn't medical education require a wholesale change if it continues to turn out "bad doctors"?

A further question might be: "If medical education is at fault, how can continuing medical education be expected to compensate for medical school and graduate medical education?"

Mandatory continuing medical education ● During the 1985 session of the Florida Legislature, mandatory continuing medical education was established as a condition for medical relicensure. The legislators clearly believed that this requirement would produce more competent practitioners. Five hours of the 40 hour biennial mandate were designated in risk management.

Florida physicians were required to accumulate a minimum of 40 hours of AMA Category I credit or its equivalent (AAFP Prescribed Credit, ACOG Cognates) every two years with the first reporting period effective January 1, 1986 to December 31, 1987.[8] Although the first effective period began January 1, the Board of Medicine did not adopt final rules until September 7. This delay placed the Florida Medical Association in the position of interpreting the law for its members eight months before written rules were established. Fortunately, the Board of Medicine considered numerous recommendations from the FMA's Council on Scientific Activities which were ultimately adopted.

Responding to the law ● Although the new law required 40 hours of CME, the attention of Florida's physicians has been focused on the five hour risk management mandate. As a result, there has been an explosion of courses ranging from sophisticated day-long conferences to one-hour blocks offered by small rural hospitals. The Board of Medicine has defined

risk management as ". . . the identification, investigation, analysis, and evaluation of risks and the selection of the most advantageous method of correcting, reducing, or eliminating identifiable risks."[9] This rather broad definition has resulted in generic as well as highly specific courses focused on subspecialties.

Sponsors of risk management courses have included entrepreneurs, hospitals, pharmaceutical companies, county medical societies, medical schools, and the Florida Medical Association. The most active sponsors appear to be the Florida Medical Association, University of South Florida College of Medicine, University of Florida College of Medicine and the University of Miami School of Medicine. The Association's program is cosponsored by the FMA-endorsed professional liability carrier, Florida Physicians Insurance Company (FPIC).

As of December 31, 1987, the FMA-FPIC program had been offered on 45 occasions with a total attendance of 4,622; the University of South Florida College of Medicine had sponsored or joint-sponsored at least 20 programs with a total attendance of 2,079; the University of Florida College of Medicine had offered both live and taped programs to at least 2,500 physicians; and the University of Miami School of Medicine had provided four courses to approximately 1,500 physicians.

At the end of the first biennium, December 31, 1987, it was not possible to determine the rate of compliance by licensed physicians.

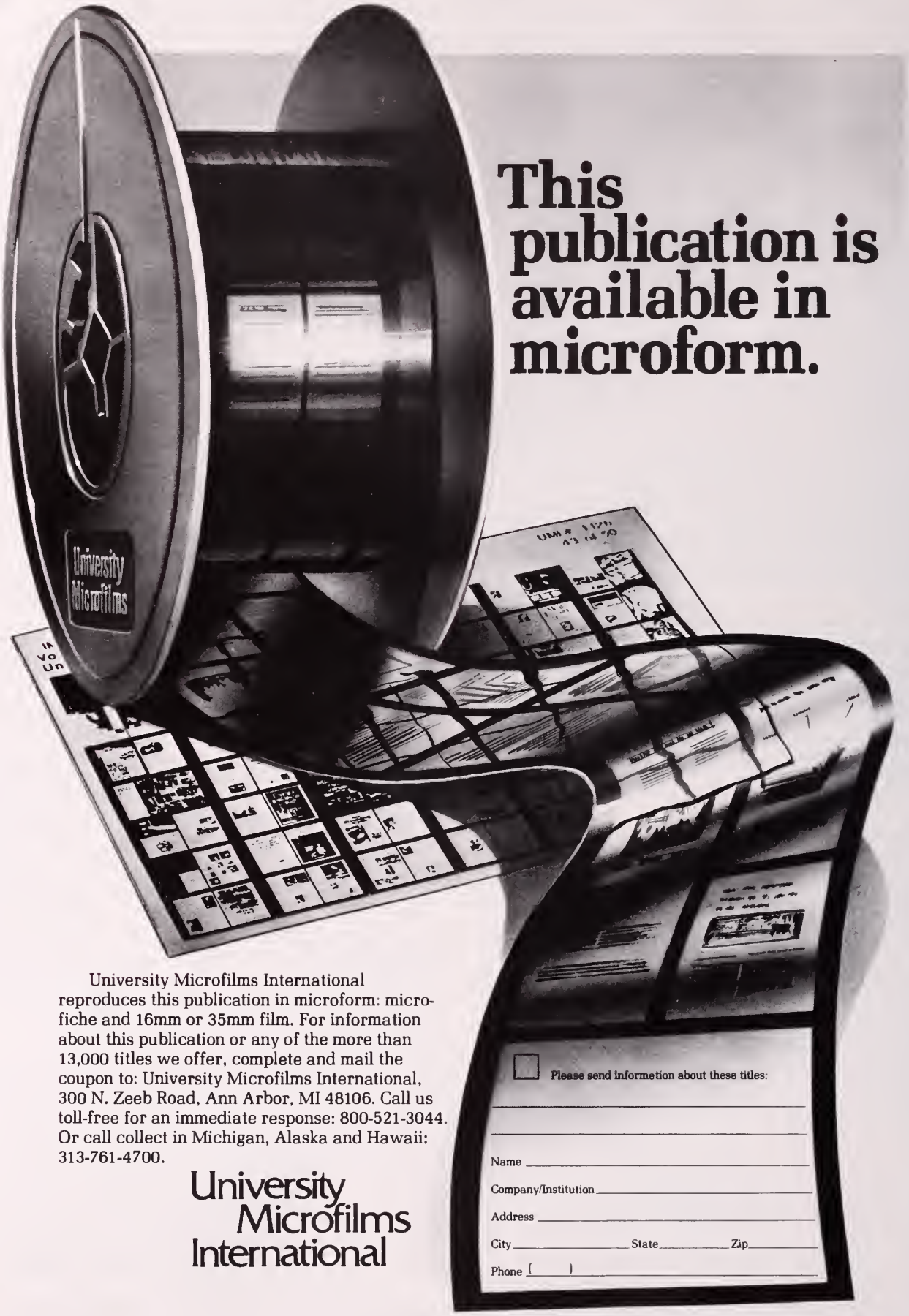
Some observations ● Although the Board of Medicine has instituted a 40-hour mandatory continuing medical education requirement for relicensure, there appears to be an inordinate concern about the five hours of risk management. This requirement is apparently viewed as somehow more important. Physicians are insisting on certificates verifying their credits in risk management while there has been no observable increase in concern over documentation of other more traditional CME activities.

It is far too soon to determine the impact of risk management CME activities on malpractice. A major problem surrounds the available data on frequency of claims. These data are an unreliable measure of actual incidences of malpractice. In addition, statutory solutions may be introduced which will have a more dramatic effect than educational activities. Although numerous problems exist in measuring the effect of mandatory continuing medical education on the malpractice crisis, risk management credits for physician relicensure may become a widespread legislature requirement.

References

1. Legislators must face professional liability issue, American Medical News, Chicago, May 23, 1986.
2. Seligson, R.W. (ed.): Florida Physician Office Guide for Risk Management, Jacksonville, Florida Medical Association, 1987.
3. Florida Medical Association, Professional Liability Fact Sheet, Reason '84, The Committee for Citizen's Rights in Civil Actions, 1984.
4. Professional Liability Insurance and Its Effect, Report of Survey of ACOG's Membership, Washington, D.C., 1985.
5. Seligson, R.W.: Interview, May 1, 1987.
6. Physicians' and Surgeons' Update: Annual Report by St. Paul, St. Paul, Minnesota, 1986, July.
7. Rydell, R.E.: President's Page, Hillsborough County Medical Asociation Bulletin, March 1987.
8. Rule No. 21M-28-002, Continuing Education for Biennial Renewal, Florida Statutes 455.213(5).
9. Ibid.

● Dr. Fore, 777 Hemlock Street, Macon, GA 31201.



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- **For treatment of infections in the:**
  - **lower respiratory tract†**
  - **urinary tract†**
  - **skin/skin structure†**
  - **bones and joints†**
- **Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets**

**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

†**Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CIPRO® SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

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Pharmaceutical Division
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Please see adjacent page of this advertisement for Brief Summary of Prescribing Information.

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C09327 MLR-261

Cipro® TABLETS
(ciprofloxacin HCl/Miles)

500 mg *B.I.D.* for most infections;
750 mg *B.I.D.* for severe or complicated infections.

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg *B.I.D.*
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg *B.I.D.*

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness, therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL: *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM: *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY: *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL: *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL: *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR: palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY: epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

- Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)
- Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%)
- Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%)
- CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

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Multidisciplinary Research Centers at the University of Miami/Jackson Memorial Medical Center

Over the past several years, medical centers have commonly used the term "centers of excellence" to describe programs of special expertise. We have designated several clinical areas within the UM/JMH Medical Center as "centers of excellence". Examples include the Center for Blood Diseases, Bascom Palmer Eye Institute, Transplantation Center, Comprehensive Cancer Center, Burn Center, Neonatal Center, Sickle Cell Center, and Center for Liver Disease.

It is important, however, to differentiate between clinical centers of excellence and multidisciplinary research centers. Although we would like to think that each of our departments, divisions and sections are the best in their particular area of expertise, we realize it is absolutely essential that we create biomedical research centers with shared resources from a variety of disciplines. These research centers must take into account the needs of the community as well as the expertise of the faculty involved.

Examples of multidisciplinary research centers established by the University of Miami School of Medicine are as follows:

Aging and the neurosciences ● In Dade and surrounding counties, over 25% of the population are 65 years of age or older. Senior citizens have many unique problems, both social and medical, which must be solved in order to assure the quality of their lives. Many of our medical problems are related to neurodegenerative processes such as Alzheimer's disease, and Parkinson's disease. Therefore it was natural to pursue this area of research with distinguished faculty members who are neuroscientists in such seemingly diverse departments as neurology, ophthalmology, physiology, psychiatry and pharmacology.

This neuroscientific expertise has a strong commitment from the Miami Project to Cure Paralysis, which in addition to its primary mission, is also dedicated to other aspects of the study of the nervous system.

Additionally, the UM/JMH Medical Center has a major trauma center that deals with a large number of spinal cord and brain injuries. It is equally important to provide the same neuroscientific expertise in resolving the problems of younger people who are involved in traumatic accidents. These studies are being supported primarily by the Miami Project.

Immunobiology ● This discipline is critical to the understanding of many medical diseases. For that reason alone, it is justifiable as a primary interdisciplinary activity crossing all boundaries within a medical school. Moreover, with the increasing challenges created by AIDS, transplantation, diabetes and neurodegenerative diseases, immunobiology has become even more important to the work of every medical school. Over the past several years the University of Miami has made an extraordinary investment in bringing together the very best immunobiologists available in this country and throughout the world.

Cancer ● Florida has one of the highest rates of cancer in the nation. This is related to an aged population but even with adjustments for age the state has an extraordinarily large number of cancer patients.

We already have one of the 20 NCI comprehensive cancer centers. This necessitates that we stay at the "cutting edge" of understanding how to solve the many challenges posed by this complicated disease. Fortunately we have recruited faculty members with the scientific expertise to make a meaningful contribution to the fundamental understanding of cancer.

Molecular biology ● Recently the Lucille P. Markey Charitable Trust awarded the University of Miami School of Medicine $6.3 million to recruit senior molecular biologists to work across multidisciplinary lines. This type of expertise is essential for any medical school to become truly prestigious in its biomedical research pursuits.

Molecular biology has become an essential dimension of all research activities. We have already recruited many fine young molecular biologists and with the support of the Markey Trust will be able to establish a major center in this important area.

Diabetes Research Institute ● The Diabetes Research Institute (DRI) will soon begin construction of a $10 million diabetes research building that will house a new and expanded basic and clinical science research facility. The primary objective of the DRI is to conduct basic and clinical research in order to accelerate the transfer of new information that will allow improved care for diabetic patients. Appropriately the Diabetes Research Institute will draw from the areas of immunobiology, molecular biology, along with many other departments within the school of medicine.

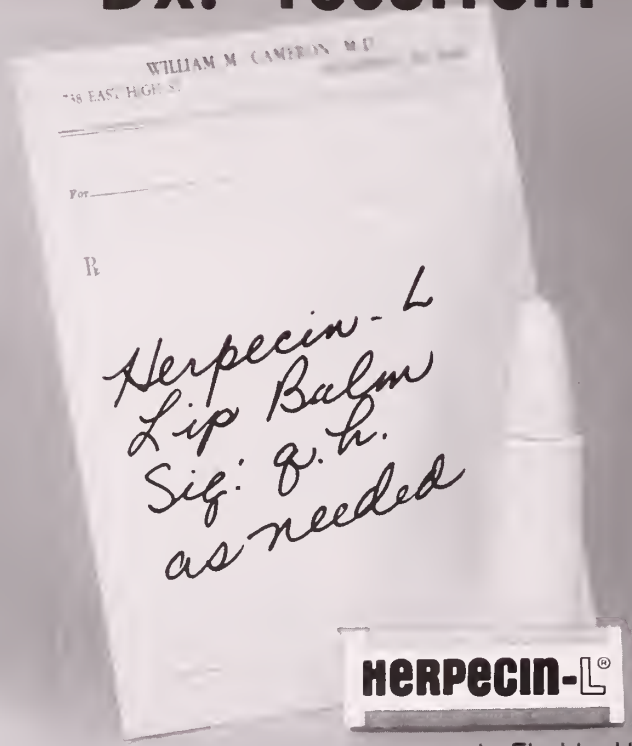
Reproductive biology ● The Reproductive Sciences and Endocrinology (REPSCEND) Laboratories form an interdepartmental and multidisciplinary unit that links the departments of biochemistry and molecular biology, and obstetrics and gynecology. There are also close ties and interactions with the departments of medicine, oncology, and anatomy and cell biology.

The major research components are in the areas of molecular and cellular reproductive biology and endocrinology. It is the latter that enables REPSCEND labs to project into many other areas, particularly that of hormone-responsive tumors. In addition, REPSCEND has already become an international training center for graduate medical students, postgraduate M.D.s and Ph.D.s, and visiting scientists who are in residence for one or two years.

The faculty of the University of Miami School of Medicine believe strongly that the multidisciplinary research approach will not only significantly enhance our research productivity but also will augment our medical education and clinical care programs. We strongly believe this multidisciplinary approach will foster greater interaction with our parent university, the scientific community in general and eventually with other institutions throughout the state. Virtually all of our recruitment and plans for construction are predicated on the multidisciplinary model built on a strong departmental science foundation.

Bernard J. Fogel, M.D.
Vice President for Medical Affairs;
Dean, University of Miami
School of Medicine

Dx: recurrent herpes labialis



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Who Gets the Meat?

Robert Graves in *Claudius the God* relates a story of a Roman nobleman whose beloved and trusted dog was sent daily to the market to carry a package of meat home to his master. One day, as the nobleman watched from his window, the dog was set upon by a pack of mongrels who fell upon the package of meat. Seeing that there was no way to protect the package, the dog thought for a second and then devised a way whereby he could retrieve the largest piece for himself. Far from being critical of his pet, the nobleman praised the dog for his cunning in beating his adversaries in an irretrievably lost situation.

The practice of medicine, in the late 1980s, seems to be similar to a package of meat set upon by mongrels. Unfortunately, we do not have the luxury of selecting the largest piece for ourselves, since the responsibility of protecting the profession falls entirely on our shoulders.

Medicine has been beset by challenges from the judiciary; for example, a federal judge mandating closer association with chiropractors and levying a fine against the American College of Surgeons and the American Medical Association after a ten year court battle. The Federal Trade Commission has imposed sanctions as "restraint of trade" against those medical bodies when they speak to prevent advertising or to police those members of the profession who engage in remedies without proven effectiveness. Legislative bodies seek to enforce their will in forcing practitioners to advocate certain modalities in the treatment of breast cancer that have yet to stand the test of time. Various special interest groups, judges and governmental agencies have invaded the neonatal and intensive care units demanding their "vote" in the arena that was once solely the province of highly skilled physicians.

Some of these changes have been brought about by the progression of technology and certainly deserve the debate of public forum. Others are the reflection of public and political fads that will probably change when another subject holds the public fancy. What is left is the patient and his physician. It is the patient who has charged us with the responsibility of his well being; it is we to whom he looks for relief at his weakest possible moment — not the courts, not the government, not the special interest groups, but the physician.

It is quite tempting to find the largest "piece of meat" and hoard it for ourselves. We are certainly capable of manipulating the system to our advantage. We can compete with one another as businessmen: open diagnostic clinics, buy hospitals, employ specialists. But can we really do this without self-effacement or jeopardizing our care for the patient? Is there not the subconscious profit motive that would lower our diagnostic and therapeutic threshold by ordering more tests, referring to hospitals with less facilities, or seeking help from less than ideal specialists? What will occur if Medicare eventually decides that they will not reimburse tests done at a free-standing diagnostic center?

Rationalizations are easy in today's context of corporate medicine, HMOs, PROs, HRS fickleness, and declining earnings. However, all of these agencies, which are not necessarily inherently bad, have only one interest at heart: the bottom line. They exist to make or save money. Although they would profess otherwise, they do not have the individual's well being exclusively in mind. So the physician and these entities must, by necessity, be in conflict. When we enter an examining room and close the door, there is just a frightened patient alone with his doctor. This has not changed, nor will it. For our patients' sake, we must adhere to the highest standards, and make unbiased decisions based on knowledge, skill and ethics.

When medicine, through its spokesman (organized medicine), attempts to correct some of the excesses, it frequently becomes the recipient of a lawsuit or a purposely intimidating investigation. It is sad that when we need our associations the most, we turn our back on them and try to go it alone. Yet, is it not our responsibility to stand by our principles and fight for them even if those with less clear insight rally against us? If we do not continue to fight for ethics and morality in our profession, make the "hard" decision in the intensive care unit, and eschew the motives of the market place, can we really blame those individuals who have replaced us?

The public continues to give us the highest confidence, above clergymen, lawyers, teachers, etc. Certainly they complain about the outrageous cost of medicine, criticize us for doing too many Caeserian sections, hold us responsible for a poor outcome and accuse us of God-like arrogance. Maybe they are partially right. But what patient sees a technican repar-

ing a CT scanner at eight o'clock on a Friday night? What mother with a healthy child complains of having had a C-section? What patient understands the desolation of a cardiologist placing a Swan-Ganz catheter into a hypotensive patient at two o'clock in the morning? And in an aura of total curability, who does not blame the physician when things go awry? Their partial understanding of the realities of medical practice in 1988 could lead to no other conclusions. Yet, the public gives us the deepest and most profound respect.

We must take the high road. Decisions must be made based on public welfare, not our own. We must continue to repulse intrusions into our profession by those persons who do not belong there, despite the consequences. We must criticize those things that deserve criticism. Our patients, who have given us this mantle of awesome power over life and death — and its responsibilities — do not deserve less.

Arthur E. Palamara, M.D., F.A.C.S.

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Peer Review Organizations: Help or Hindrance

In March, the Florida Medical Association (FMA) conducted its Annual Leadership Conference in Jacksonville. One invited speaker was William Winkenwerder, M.D., the Special Assistant to the Administrator of the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, the governmental agency responsible for administering Medicare and contracting with Peer Review Organizations (PRO). After Dr. Winkenwerder described the Federal Government's plans for reducing payments to physicians and enticing more physicians to become participating physicians, audience reaction was, as expected, lively. In fact, it bordered on hostility. The particular subject that brought most discussion, and the one which I will address in this article, relates to PRO activities. Dr. Winkenwerder, himself a young internist, but with virtually no practice experience, seemed cool in his response to the frustrations of physicians in the audience who described personal encounters with the Professional Foundation for Health Care, Inc. (PFHC), the Tampa-based PRO contracted by HCFA to review inpatient hospital services provided to Medicare patients in the state of Florida. One physician in the audience detailed his own experience with a Medicare patient who was actively hemorrhaging, admitted with hypotension and who subsequently received several blood transfusions before a D&C was performed to stop uterine bleeding. The hospitalization was deemed inappropriate by the PRO!

Soon after I returned from that meeting, I myself was notified of a PRO denial for one of my patients with terminal cancer who could no longer remain at home, having become severely dehydrated and hypotensive. Even though terminal, she and her family desired intravenous hydration and IV medications for comfort, for which reason hospitalization was necessary. This patient remained in the hospital 18 days with a steadily-declining course and died in the hospital. In spite of excellent record documentation, the PRO issued a denial on the basis that "services rendered did not require an acute level of care." Incidentally, in addition to the denial, the PRO further added insult to the incident by notifying the expired patient of the denial. Luckily, this is my only personal experience with a denial, but having recently chaired the Quality Assurance Committee and the Medical Care Evaluation Committee responsible for interacting with the PRO at a large local hospital, I know of numerous denials at least as flagrantly unjustified as these just cited. In my own case, I have written Dr. Charles B. Slonim, Medical Director of the Professional Foundation for Health Care, Inc., to level my strong objection to the decision of the PRO.

On perhaps a more positive note regarding the PRO, we have recently learned of a settlement of the lawsuit filed on behalf of several hospitals in the Florida Hospital Association against the statewide PRO because of the PRO's failure to follow guidelines in contracts that were signed by hospitals where inpatient services provided to Medicare patients were to be reviewed by the PRO. Several sections of that settlement are very important and should prove to be very beneficial to hospitals and medical staffs. Quoting from a memo sent to all hospitals by the Florida Hospital Association, "some key settlement

stipulations include: The PRO has agreed to expand the times for discussion opportunity between the attending physician and the PRO physician advisor who makes the initial denial determination. The PRO has also agreed that the physician advisor. . .will identify his or her particular specialty to the attending physician.''

Referring to the PRO physician advisor, my own experience has been noteworthy. When the PFHC received the contract from HCFA to be the statewide PRO, it actively recruited physicians to become physician advisors responsible for reviewing charts that had been screened by RNs to determine if hospitalizations and continued stays were necessary. I agreed to become a physician advisor and was asked on several occasions to meet with the RN who had screened records from hospitals where I did not practice. More than fifty percent of the time I did not find reason to deny hospital reimbursement. Whether for that reason or some other, I quickly was dropped from the list of physicians regularly called to do chart reviews. My own assumption is that I was not denying enough cases to be ''worthy'' of the position of physician advisor. In my role as chairman of the hospital committee responsible for utilization review, I learned the names of physician advisors doing case reviews for that hospital. These physicians were, in my estimation, not the best trained members of our profession. I feel that only the best of our profession should be judging the activities of physicians. I am afraid that is not the case with the PRO in our state.

I suppose the purpose for writing this article is to let you know that the leadership of the FMA and the Orange County Medical Society are as concerned as most of you about PRO activities. In Jacksonville, this dissatisfaction and frustration was **clearly** articulated to an administrator of the Federal Government ultimately responsible for contracting and administering peer review activities. Individually, as providers to Medicare and Medicaid patients, we have the responsibility as their advocates to notify the Professional Foundation for Health Care, Inc., when we disagree with a denial and wish for an appeal and further when we disagree with the outcome of a reconsideration. I chose to communicate through their Medical Director, who hopefully will listen inasmuch as he is also one of us. Furthermore, when we have major difference with a decision of the PRO and we clearly believe their actions are not in the interest of quality patient care, we should bring that to the attention of the FMA which will serve as a repository for these complaints and serve the physicians of Florida in every way possible to see that the rules and regulations promulgated by the federal government are followed and fairly applied. If you have a personal experience which should come to the attention of the FMA, you should record your experience and send that to Mr. Robert Seligson, Director, Division of Programs, Florida Medical Association, P.O. Box 2411, Jacksonville, FL 32203.

Clarence H. Brown III, M.D.

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Needed: A Ship's Captain

The editorial pages of professional publications are filled with pessimism. The golden age of medicine has brought gloom to practitioners and distrust to the public.

If we can do so much in providing health care, why is there such broad dissatisfaction? Is it possible to conclude that the better we become in providing health care, the worse we become?

Such a paradoxical statement is not only grammatically clumsy, but it must be untrue. As we have learned in training and in practice, few things in medicine are clearly true or false.

Technically we are better. The extraordinary abundance of this technology has over-burdened the system and thus, in essence, made it worse.

How is it that the system is so unprepared? In this instance, trial lawyers and politicians must not be blamed. It is we, the health providers, who have abdicated.

The public is looking to us as the ''captains of the ship'' for guidance. I fear that ''we captains'' are all too often overly enthralled with the application of medical technology. There is little attention paid to the quality of the outcome.

During a period spent interviewing medical school applicants, I was impressed by the large pool who had, as a common denominator, a seemingly sincere desire for social good.

Exposure to medical staff problems has demonstrated a propensity for our present training

system to dampen this social consciousness in the finished product.

Please don't conclude that the finished physician is made more detached and less caring than the average mortal. It appears that they are programmed to seek the preservation of life through technology as single-mindedly as those who went in search of the Holy Grail. So often this results in the preservation of "life" in a corpse.

All indications are that the system is indeed "broke" and therefore needs to be "fixed." There are indications that the number of physicians graduated is excessive and their distribution geographically and by specialty is askew.

Medical schools are expensive. We need fewer of them. The entire training program should be oriented toward producing well-trained, socially-conscious primary care physicians. Only after "seasoning" in primary care should those who desire to seek subspecialization be encouraged to do so through never-ending, hospital-based training programs.

To mandate economic equality between hospital-based subspecialists and primary care physicians is blasphemous but nevertheless necessary if the system is to work. Those of us with present day six-figure incomes must look for readjustment.

A conscious effort needs to be made through training and selection to develop greater physician interest, expertise and leadership in public health and health delivery administration.

We must be wary of subjugating ourselves and our patients to the ethics of the corporate manager. The medical-industry complex is an ever-growing giant. Perhaps physicians can, through careful planning, infuse some benevolence into this giant's psyche.

Perhaps this, more than anthing else, is the line of strategy we should be debating in our societies.

Alexander D. Brickler, M.D.
Tallahassee
Editor

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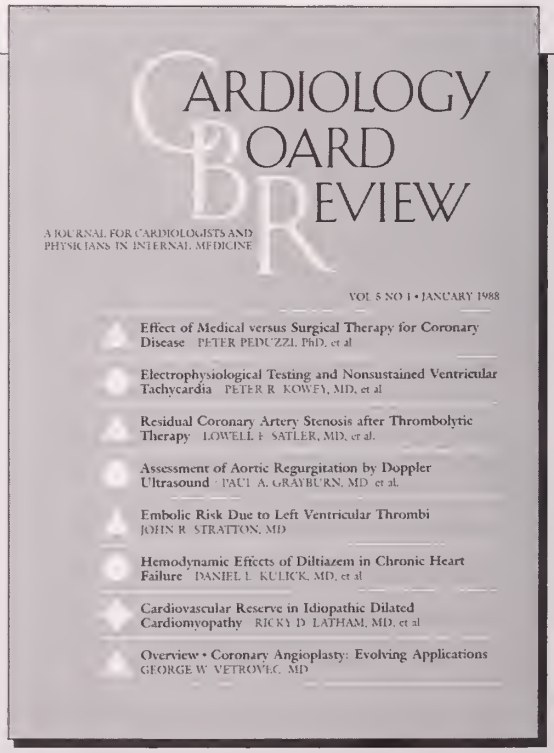

*Journals reviewed include: *Circulation, American Heart Journal, Journal of the American College of Cardiology, British Heart Journal, Chest, The American Journal of Cardiology, The New England Journal of Medicine, Annals of Internal Medicine, American Journal of Medicine*, and *The Journal of the American Medical Association*.

Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

Owning a Business: Is It Worth It?

This is a question I have asked myself over and over again for the past year. I have been in business for almost ten years and, finally, had to make a choice: My lease expires July 31, my manager and right-hand helper is retiring after being with me from the beginning, and a major construction project on the roads leading into the shopping center is about to start. Had I written this article two weeks ago, the ending would have been different.

Sixteen years ago, my husband, a pathologist who had trained in New York, found the perfect position in Tallahassee. I had been an international airline hostess based in New York City before we were married and had learned to love the city. After visiting Tallahassee we decided that it was the perfect place to live. The people we met were so nice and the city lovely. It wasn't like New York, but then we did not want to raise our family there. So, we moved, settled in, had our second child, and I began volunteer work. I was on seven community boards, Chairman of Altar Guild at church, and Chairman of the Civic Ballet Fashion Show which I initiated and which is, I believe, still going. This was fun for a while, but I began to miss New York.

About this time I met another doctor's wife and eventually we decided it would be "fun" to have a dress shop. One thing led to another and finally the opportunity presented itself. We heard through a friend of a shopping center about to be built. That night I told my husband that I had looked at plans for a store and much to my surprise, he said something to the effect that if I did not do it someone else would. So, within a short time, we had hired a public relations firm to help us with advertising, a logo, etc.; we hired a CPA; we went to the bank for a loan; and then went to New York for an exploratory buying trip. We also went through catalogs and picked out dresses we liked and made appointments with those manufacturers — 40 total.

Weather problems delayed the opening of the shopping center. The clothes were starting to be delivered, and we had no store. What to do? We opened, by invitation only, in my partner's house. We had a full staff there including an alteration person working off the dining-room table and were successful beyond our wildest dreams.

Our children had started school by the time the store was complete. We would leave the store at 3:00 p.m., pick up our children and take them to various activities. We did not work Saturday and we both had mothers to help with babysitting. That's how we managed to cope with family responsibilities and business demands. It worked very well, and we had the best of both worlds.

After a few years it became apparent that only one person should be running the store and, after much discussion, I bought out my partner. Although we had many employees through these ten years, our manager has stayed with me and offered not only stability but also a "sounding board."

My family has been pretty supportive, but I have to admit there have been times when I know my husband and/or children wished I did not have the store. Sometimes I, too, wished I did not have the store. There are times like Christmas when everyone seems to find a reason they cannot work. Guess who takes over? Also, I sometimes envy friends who have "leisure time." I see them being so gracious and enjoying lunch with friends. They are able to travel and talk of trips to Europe and other places. For me to do that would take an immense amount of planning and scheduling and even then I probably couldn't relax, wondering how the store was doing. Something else happened, though; these friends envied me.

So now, about my soul searching. After ten years in business and eight years of running the whole show, I began to dream of a more peaceful, relaxed kind of life. I was getting burned out and for all the reasons previously mentioned I was actually anxious for the lease to expire. I couldn't wait to escape the responsibilities and problems that come with owning a business. Ah, light at the end of the tunnel, that's all I could think about.

Then a funny thing happened. People began to say to me: "I've heard you're going to sell the store. How can you do that? Where will I be able to shop now? What will you do with yourself now that you've had your store for ten years? Life will be boring. You'll feel guilty when you go to New York now because there won't be a reason for it other than to spend money."

I did tell my husband I wanted to be able to go there six times a year still so I could get my hair cut and buy shoes for my hard-to-fit feet. That did not go over very well, three times maybe but not six. My children, both in boarding school, said "Mom, what are you going to do all day? You'll not be happy — the store is your life."

Well, I finally had a chance to sell my store. Not only that but it was a perfect situation where I would still be able to go to New York on buying trips, plus I could work daily or whenever I wanted. On the day the contract was delivered, an employment agency, unsolicited, called and asked if I needed a manager because "she had one that would be great."

Well, with these two developments happening back to back on the same day, life was *really* getting complicated. I mean, didn't I want to get out of business as soon as possible so I could pursue leisure? Of course, right, well, maybe not after all. My husband and I took a five-day anniversary "vacation" and guess what we did? The first three days were spent writing pro and con lists on the good and bad sides of owning my own business. My dear husband was not much help with my decision. It was my decision and he did not want to be blamed if I made the wrong one. All he would tell me was, "It's up to you."

By the third day of our vacation, after my walking six to eight miles every day on the beach, things were coming into perspective. What *would* I do with myself after having the excitement of the store every day and with both children now in high school and about to go to college? Also, nagging doubts began about how I would feel working for someone in "my" store. It became clear to me that what I really needed was a manager to take over when my present one retired. I didn't need to sell the store. I would hand over more responsibility to my manager than I had in the past. In that way, I would be able to keep my store but also have more time to do the things I wanted to do.

Much to my delight, now that I have made the decision to sign another lease and keep the store, everyone seems so happy for me, especially my family. They seem proud of me. Last week when I was in New York on another buying trip, it was like "old home week." All my friends from the showrooms in New York were so excited for me. There were hugs and kisses and tears all around. In the coffee shop where I go for breakfast, I felt like a celebrity. As I left on the plane to come back home, I kept congratulating myself for having made the decision I did. I felt so good about it. I know there will be rough times ahead but they will be better than the alternative, at least for me.

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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

JULY

Family Practice '88, July 5-8, Hilton Hotel, Orlando. Contact: Shelburn Wilkes (305) 898-1695.

Basic Trauma Life Support Provider Course, July 9-10, USF College of Med., Tampa. Contact: James Hillman, M.D. (813) 251-6911.

8th Annual Cancer Conference, July 9-11, Colony Beach Resort, Longboat Key. Contact: Henry A. Azar, M.D. (813) 974-3133.

Breastfeeding: Science Behind Success, July 13-15, Hilton Hotel, Lake Buena Vista. Contact: Carol Kolar (219) 462-4027.

Basic Trauma Life Support Provider Course, July 23-24, USF College of Med., Tampa. Contact: James Hillman, M.D. (813) 251-6911.

Risk Management Seminar, July 30, Holiday Inn, Ft. Lauderdale. Contact: M. P. Demos, M.D. (800) 431-3878.

AUGUST

Otolaryngology for the Practicing Pediatrician, August 4-7, Mariner's Inn, Hilton Head Island, South Carolina. Contact: Debbie Shealy (803) 798-6207

ACLS Provider Course, August 6-7, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911

Fundamental & Clinical Aspects of Internal Medicine, August 7-20, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Arrhythmias: Interpretation, Diagnosis and Management, August 19-20, Grand Cypress Hyatt, Orlando. Contact: Deborah Wilderson (800) 421-3756.

Risk Mamagement Seminar, August 20, Holiday Inn, Coral Gables. Contact: M.P. Demos, M.D. (800) 431-3878.

SEPTEMBER

19th Annual Pediatric Labor Day Symposium, Sept. 2-4, Pensacola. Contact: Garth Grove, M.D. (904) 474-7101.

Magnetic Resonance Imaging A Technologists New World, Sept. 15-17, Holiday Inn, Lake Buena Vista. Contact: Martin Silbiger, M.D. (813) 974-2538.

Pediatrics for the Practitioner — Update on Infectious Diseases, Sept. 16, Sheraton Tampa East, Tampa. Contact: Herbert H. Pemerance, M.D. (813) 974-2538.

Current Concepts in the Diagnosis & Treatment of Adult Heart Disease, Sept. 16-17, New World Landing, Pensacola. Contact: Phyllis Connerley (904) 478-4460.

ACLS Instructor Course, Sept. 17-18, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

Basic Cardiac Life Support for Physicians, Sept. 19, University Comm. Hosp., Tampa. Contact: Jim Connolly (813) 972-7270.

Rehabilitation of the Post-MI Patient, Sept. 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

OCTOBER

Basic Trauma Life Support Provider Course, Oct. 1-2, University South Florida, Tampa. Contact: James Hilman, M.D. (813) 251-6911.

Heart Disease, Emotions & Stress, Oct. 5, Tampa. Contact: Stephen Glasser, M.D. (813) 974-2880.

ACLS Provider Course, Oct. 15-16, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

VI Annual Advanced Neuroradiology Seminar, Oct. 21-23, Hyatt Regency Hotel, Orlando. Contact: Agnes Bridges (813) 251-7778.

29th Workshop in Electrocardiography, Oct. 26-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry J.L. Marriott, M.D. (813) 894-0790.

Risk Management Seminar, Oct. 29, Holiday Inn, Altamonte Springs. Contact: M.P. Demos, M.D. (800) 431-3878.

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Feature Editor — **Dale C. Havre, M.D.**

Medicine Is a Profession, Not a Business

The word "profession" has an interesting background. It is related in meaning to the vows taken by persons entering a religious order. Appropriately, a profession is often referred to as a calling. When a profession is viewed as a calling, it implies that the individuals who comprise that profession are primarily concerned with the conduct of their work rather than the collection of the rewards, monetary or otherwise, that the work generates. As this concept of professions evolved, it seemed natural to believe, for example, that lawyers would be interested mainly in the law and their clients, physicians in medicine and their patients, and the clergy in religion and their flocks.

At a recent meeting of independent physicians, however, I learned from the guest speaker, a management consultant, that medicine is a business. There was no doubt in his mind that our calling is first and foremost a business. He intimated that I was naive to believe otherwise, and I was advised that if I wanted to put altruism before profits, I should hop a plane for a third-world country, medical bag in hand, and go to it for the love of mankind.

My understanding of a business is that it is an activity one engages in to make money. It is an enterprise, not a calling. I believe that if entrepreneurship is what medicine is all about, then medicine would never have been called a learned, and certainly not a noble, profession. With the growing commercialism in medicine, though, I can understand how the public and even some of the members of the profession itself are caught in a web of ambivalent feelings.

It is essential that those of us who want to see medicine survive as a profession speak up in defense of our calling. Because it is such an emotional issue, and because I would like to remain as objective as possible, perhaps an examination of an analogous situation in another profession would be useful.

Many of today's clergy are very well trained in counseling. Providing emotional support and spiritual guidance to troubled parishioners are duties clergymen undertake with respect, joy and sometimes trepidation. Along with performing marriages, baptisms, and officiating at funerals, it is part of the profession. Although they do receive remuneration for being clergymen, most are not motivated by money to do their work. There are some who are more interested in financial gain than saving souls, however, and I do not think it is difficult to recognize them.

If you see a preacher on TV who promises to get you into Heaven for $59.95 down and $19.95 a month for the rest of your life, you might wonder how he can do the job so cheaply or, more realistically, who's going to keep the books (God or the preacher?). If the pastor in a neighboring community begins to advertise in your local newspaper because he wants to siphon people away from your church, you might begin to get suspicious. If the same preacher parks his bus in your church's parking lot and offers to give you a free ride to his establishment, you've got even more reason to question his real motives. And if he takes out a full-page ad in the Yellow Pages to call attention to his low rates for counseling services, you know instinctively you've got a businessman on your hands, not a clergyman.

Yes, there is a difference between a profession and a business. There is nothing wrong with conducting a medical practice in a businesslike manner, but the public does have cause for concern if medicine is practiced primarily as a business. In the former case, one would hope that the efficiencies of the paractice are first passed on to the patient as more time for individual attention and as reasonable fees while, secondarily, the doctor receives the satisfaction of doing a better job and earning a fair profit (no, profit is not a dirty word). When medicine is practiced *as* a business, however, patients instinctively realize that fact sooner or later, just as they learn to be suspicious of the evangelist with a garage full of Rolls Royces. And when even one patient has to worry about whether the doctor is more motivated by his accountant than by his calling to heal and teach, then all of society, doctors included, is in deep, deep trouble.

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported. It was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

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Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

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Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively. PV 2091 AMP [041288]

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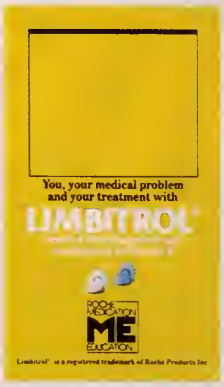

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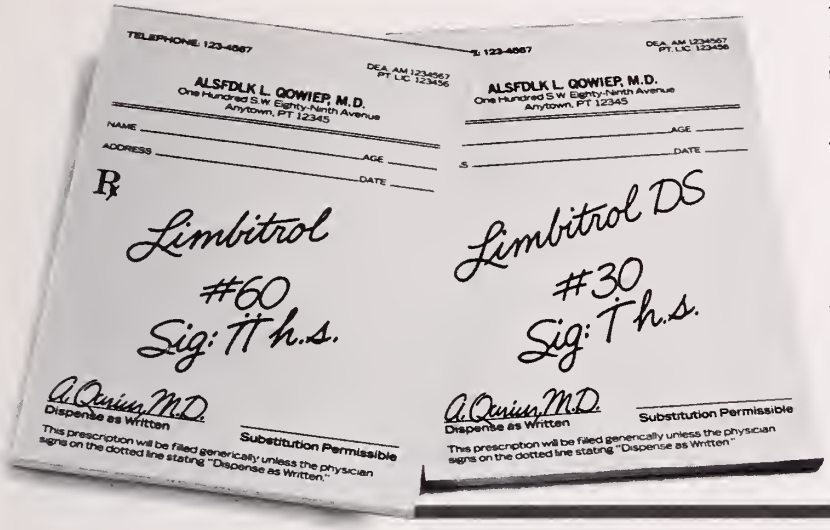

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

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Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady - state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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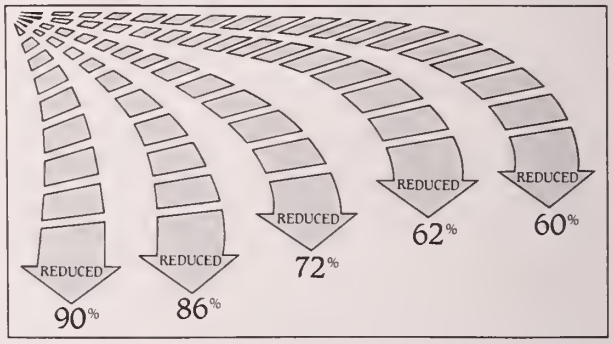

*Patients often presented with more than one somatic symptom.

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A "Florida Still Life" captures the luxuriant beauty of midsummer flowers in full bloom. The work of Dutch artist Cornelius van Spaendonck, this month's cover is courtesy the Cummer Gallery of Art in Jacksonville and, in essence, beautifully portrays the "silent poetry" described for such works by Simonides.

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PRESIDENT'S PAGE

Phase 3: Girding Up to Educate the Public

Phase 2 of our constitutional amendment campaign is nearly complete. By the time you read this, we will have garnered over 460,000 signatures and submitted them to be certified by the county election supervisors. I am proud to tell you that over 80% of these signatures were obtained by you and/or your spouses and, in some instances, your office staff. This was a highly successful effort and you are to be congratulated for a job well done.

We now approach Phase 3 which will be the educational phase. We must gear up to educate the public as to the cause of the liability insurance crisis and how it can be corrected. Our very capable campaign staff will be traveling to ten or more sites throughout the state, conducting training sessions on television, radio and public speaking techniques to better get our message across. They have already drafted a 15-minute presentation which will be suitable for civic club meetings.

Please be thinking of the best available talent in your counties so that when the training session comes to your area, we will have the best people. Don't forget the auxilians, many of whom are excellent public speakers and knowledgeable about our problem.

With regard to our assessment, we are just over the $3.2 million mark and we must reach a minimum of $5 million. We are starting a peer-to-peer program so that those who have paid will be asked to seek out those who have not. Please remember that we are going to win this fight, but we must have adequate funds to get the job done.

In the last few weeks before the election, we are going to need 5,000 physicians plus as many auxilians, children and friends as possible to walk every neighborhood in this state in a door-to-door campaign seeking support of our amendment. Those of you who went to the polls on Super Tuesday saw just how willing the public is to help us. This door-to-door campaign will give all the other physicians a chance to participate and it will go a long way toward curing our apathy.

Thanks again for all the help you have given YOUR FMA. We are going to win in November.

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EDITORIALS

Judging Physicians Is No Job for Bureaucrats

The latest grand idea to come out of the think tank at the HCFA is an ambitious scheme to measure the performance of physicians who take care of Medicare patients. But the plan does not stop there. The HCFA, in addition, plans to publicize the ratings ostensibly to let Medicare patients know where their own physicians stand. This grandstand ploy has already generated a lot of publicity, but it sounds like a kooky idea to me. I have doubts that the HCFA is qualified to do the job and am even more skeptical about how the public should view the ratings report when it comes.

Measuring the quality of medical care is nothing new to physicians; they have been engaged in this activity for a long time. Whether one calls it peer review, medical care evaluation or quality assurance, the measurement of physician performance has been a primary priority of hospital medical staffs across the country. Despite their relative lack of immunity and other limitations imposed by law, physicians have done a reasonably good job in monitoring the type of care rendered by their colleagues. I can testify to the effectiveness of the peer review process in the context of my 18 years in private practice and as a long-term member of a hospital medical care evaluation committee.

New members of the medical staff, for example, are subjected to a rigorous review of their performance during probationary periods before they are given full hospital privileges. Established staff members, on the other hand, continue to be reviewed periodically to make sure they keep up with advances and new knowledge in their fields. Those failing to meet minimum standards may be required to obtain additional training, have their privileges modified, or even suspended from the medical staff if a question of gross incomptence comes up. Physicians whose privileges are suspended are reported to the state Board of Medicine which has the authority to suspend their license to practice.

Such reviews of physicians' clinical activities, which are mandated by the JCAH, assure the public that it is getting only competent care from physicians. A few substandard physicians no doubt escape this protective net, but that is a rare occurrence.

If physicians are doing a good job looking over the shoulders of their colleagues, why is the HCFA so eager to do the same job? HCFA contends that as the fiscal arm of Medicare, it feels morally obliged to provide elderly patients with competent medical care, but that sounds quite dubious to me. Additionally, there is still a widespread but erroneous public perception that physicians cannot be trusted to judge their own colleagues, and that a conspiracy of silence exists to protect those who are incompetent.

I am sure physicians are all for rendering the highest possible medical care to the public, but I dread the thought that unqualified bureaucrats are going to take over a crucial function of the medical profession. I also revolt at the idea that Medicare patients are being fed a bunch of hogwash without knowing anything about it.

They ought to know more about this scheme before another disaster befalls us.

The proposed plan by the HCFA, first of all, is an unwarranted usurpation of a function that legitimately belongs only to physicians. It is also an unneccessary and expensive duplication of what physicians have been doing over the years. Physicians, by virtue of their background and experiences and through hospital medical staffs, are best qualified and equipped to review the performance of their colleagues; bureaucrats and their hired guns, on the other hand, are poorly qualified and ill-equipped to render judgments on a complicated process for which they have no background and training. The situation is akin to having Dolly Parton appear at the Metropolitan Opera to sing the arias of Verdi instead of Kiri Te Kanawa.

Secondly, the government has a sorry and sordid record in messing up things where it has tried to intervene before. The PRO is a good example, and the bloody mess is still spilling all over. The only people who think the PRO is a good thing are the same bungling bureaucrats and their toadies who don't care a hoot about the interests of patients.

But most of all, the logistics of carrying out a complex process of assessing the performance of physicians and then rating them are quite formidable. HCFA appears to believe it can quantify physician

performance, but that is absolutely impossible to do. Quality assurance activities at best tell us whether physicians are rendering competent medical care or not, and winnow those who are incompetent or substandard. There is no way that they can tell us whether Dr. A is better than Dr. B in removing gallbladders, or whether Dr. C is better than Dr. D in taking care of patients with heart attacks. To think that HCFA can do this and then disseminate the information to the public is folly of the highest degree.

Physicians have no quarrel with the HCFA in exercising its right to find out where its Medicare money is going, but they ought to object vigorously when it tries to appropriate what should be a sole prerogative of the medical profession. Judging physicians and the work they do is too important a matter to leave to the puny minds of bureaucrats.

R. G. Lacsamana, M.D.
Editor

A Vote of Approval

Recent national polls show that public approval of physicians has increased for the second time in 20 years. This was good news even though the increase was only 2% last year and 2% this year. Of course, this has to be offset against the fact that over the past 20 years public approval rating dropped 20% to an all time low. This trend apparently started in the mid-1960s and steadily went down for 20 years until two years ago when the reversal began. Granted, it is 2% a year but that represents a watershed in the public's perception of the medical profession. At the same time attorneys' ratings continue to plummet and have shown no signs of bottoming out as the public continues to show disapproval of the legal profession.

As I stated in other editorials, the legal profession has no one to blame but itself just as we have no one to blame but ourselves for the decline in public approval for the last 20 years. By the same token we have no one to praise but ourselves for the reversal and the slowly improving perception by the public. This has not come about by mandated edicts by the state or federal government but because the medical profession has been willing to examine itself and determine what the public does not like and to see if these points are valid or invalid. In most cases what the public did not like was found to be valid and the medical profession has worked hard at improvement. Of course it will take ten to 15 years to regain our former level but this is a goal certainly worth working and waiting for; we do have positive feedback from the public.

These cycles of public approval and disapproval are not new to the medical profession and can be traced back for the last 200 years in America. There are instances when the profession ranked very high in the public's opinion and at other times very low. The times when it ranked very low usually have led to changes to meet the criticism and bring the profession back into the mainstream of American thought. This was certainly the case in the early 1900s when the profession and the healing arts were under a great deal of criticism because of poor academic standards and the fact that this was perceived to be detrimental to the health of Americans and irresponsible on the part of medicine. Of course, this had largely been a response to American thought in the mid-1800s which had demanded that more physicians be trained even though they were poorly trained by the apprentice system, which was a very inconsistent method. The scientific method did not evolve until the late 1800s and the profession itself was not entirely to blame for the low academic standards of the early 1900s. However, when the public demanded changes, most of the profession attempted to bring about these changes. This, of course, culminated in the Flexner Report of 1909 which changed the academic standards of medicine and the system of medical education in the United Stated as never before.

The profession has usually responded when medical practice is viewed in an unfavorable light. This has been the case over the past few years when most physicians began to realize that they could not conduct themselves as they did in the 1960s and 1970s when public opinion, which we so desperately needed in order to carry on our work, was slowly eroding. It is now apparent that public opinion is coming back to our side and even though it is growing slowly this is certainly a favorable trend.

Inasmuch as our petition drive for the constitutional amendment in November depends upon public approval, it is no wonder that opinion polls concerning the amendment show a favorable response. The people still respect physicians, they trust physicians and are intelligent enough to know that the practice of medicine is in trouble in the state of Florida due to circumstances beyond physicians' control. The public does believe us when we say that putting a $100,000 cap on noneconomic damages would help to alleviate the burden

of medical care in this state.

Good things come to those who wait and even though it has been a 20 year drought, as we have watched our public opinion support slowly dwindle away, it is doubly rewarding at this particular time to see public opinion coming back to our side. I am sure that in an historical sense there will be periods in the future when public opinion will dwindle away and we will enter another cycle of decline. However, that is not the case at present and I say we should enjoy it and bask in it as much as possible and continue to do the things that will rally the public to our side.

H. Frank Farmer Jr., M.D., Ph.D.
New Smyrna Beach

What About Being More Responsible?

Many Americans cheered and exulted at a recent court decision that found a tobacco company partly guilty in causing the death of a smoker from cancer of the lungs. Those who have been fighting the tobacco companies unsuccessfully over their products saw in the rare court victory an opportunity to open the door further for more lawsuits in the future, pressure the tobacco companies economically, and perhaps paralyze them forever. I, too, like many other Americans, would like to rejoice at the prospect that tobacco companies may stop manufacturing cigarettes five, ten, or 15 years from now, but I also get chilled at the idea that it takes an economic blackmail to stop Americans from smoking. What is there to rejoice about when we cannot kick a bad habit through our efforts?

We are all familiar with the notion that a number of common illnesses are caused by dangerous and unhealthy lifestyles. There is certainly no dearth of information about the dangers of smoking, excessive drinking, and overeating. As physicians practicing preventive medicine, we hammer daily into our patients the need for moderation and abstinence particularly where the possibility of addiction to certain substances may lead to cirrhosis, cancer of the lungs, obesity, hypertension, and diabetes mellitus. The choice to stay well or get ill is ours alone and we ought not to be pointing an accusing finger at Liggett and Myers or Seagrams when things go wrong. As long as we live in a society where the sale of alcohol, cigarettes, and other substances is legal, and where we are free to make choices despite all the appealing ads and other blandishments, we should take sole responsibility for the consequences of our actions. Taking refuge in a court judgment that found a tobacco company partly responsible for a patient's addiction to cigarettes is an empty gesture and a Pyrrhic victory at best.

Tobacco companies, like any other business, resort to a variety of techniques to seduce the public to buy their products. There is nothing wrong with this if their ads are not misleading or deceitful, and as long as they disclose the dangers of cigarette smoking as they are required to do by law. A number of cigarette ads are indeed seductive, but that should not prevent rational individuals from making informed decisions on whether to buy cigarettes or not.

I refuse to think that we can succeed in banning cigarette smoking only through threats of lawsuits and economic coercion. What about modifying our behavior? What about being more responsible? If we cannot stop people from smoking, why should we think we can stop them from committing other stupidities? We might as well stop pretending that preventive medicine works. It may well be that the last, dying embers of the cigarette industry will be extinguished in a court of law, but I am not sure that I will exult and celebrate.

R. G. Lacsamana, M.D.
Editor

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. 2. Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980,4(6):392-397. 3. Skoutakis VA, Carter CA, Acchiardo SR. Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION SEE PACKAGE INSERT)

INDICATIONS AND USAGE

BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS

Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see DVERDDSAGE).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS

Hyperkalemia (See DVERDDSAGE).

In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics

Hyperkalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions

Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis

Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS

General:

The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients

Physicians should consider reminding the patient of the following:

To take each dose without crushing, chewing, or sucking the tablets.

To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.

To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.

To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests

Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions

Potassium-sparing diuretics, see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C

Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers

The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and DVERDDSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE

The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION

The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

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IN MEMORIAM

Frank C. Coleman, M.D. Man of Many Talents

Frank C. Coleman, M.D., who in 1984-85 served as the 108th President of the Florida Medical Association, died in Tampa on Sunday, June 5, 1988. He was a native of Jackson, Mississippi, and was born there on May 14, 1915.

Dr. Coleman received an undergraduate degree from Mississippi College and a medical degree from Tulane University School of Medicine in 1941. He served an internship and residency in pathology at Touro Infirmary in New Orleans. He was certified by the American Board of Pathology in Clinical Pathology, Anatomic Pathology, Forensic Pathology and Blood Banking.

Following residency training he served as director of the Department of Pathology at Mercy Hospital in Des Moines, Iowa, for 20 years before moving to Tampa as the managing partner of Patterson-Coleman Laboratories, which he developed into one of the largest independent medical laboratories in the southeast. He retired from the laboratory in 1977 and served as a consultant in pathology and laboratory management to institutions throughout the country. Over the years he was staff pathologist and consultant to many hospitals in the Des Moines and Tampa areas.

Although Dr. Coleman was long recognized as an outstanding practicing pathologist, his interests and abilities took him far beyond the ordinary activities of a practicing physician. He provided leadership to many organizations, both medically related and those not related to medicine — medical education, political and legislative activities, socioeconomic matters affecting health care, multiple medical organizations, and numerous community affairs.

In educational activities Dr. Coleman developed a residency program in pathology while in Iowa and programs for training medical technologists both in Iowa and Florida. He served as Clinical Professor of Pathology at the University of Iowa College of Medicine and later at the University of South Florida College of Medicine. He was chairman of the Medical School Committee of the Tampa Chamber of Commerce, a panel which played a key role in establishment of the College of Medicine. He was a trustee and president of the American Board of Pathology. While a member of the Iowa State Board of Medical Examiners, he was elected as secretary. Recently, he served as a member of the Board of Regents of the Uniformed Services University of the Health Sciences. In January 1988, President Ronald Reagan appointed him chairman of that board which is responsible for the overall policy and management of the medical school operated by the United States Armed Forces.

In political and legislative affairs he began his career as a member of the legislative committee of the Iowa Medical Society. He was soon selected as a member of the Council on Legislative Activities of the American Medical Association and served a term as its chairman. While a member of that Council he identified the need for a separate political arm of organized medicine and was instrumental in organizing the American Medical Political Action Committee which he served as an early chairman. Over the years he was actively involved in the campaigns of candidates for political office from the local levels to the presidency of the United States. His work as a member of the board, as treasurer, and later as president of the Florida Medical Political Action Committee is well known to Floridians.

Dr. Coleman was an expert in health manpower issues. His service as a member and chairman of the Council on Health Manpower of the American Medical Association was important in development of his skills in this field. He was one of few individuals who have been chairman of more than one AMA council with chairmanships of the Councils on Health Manpower and Legislative Activities. He was a member of the subcommittee on Professional, Scientific and Technical Manpower of the National Manpower Advisory Committee of the U.S. Department of Labor. He served a term as chairman of the Council of Health Manpower of the Florida Regional Program.

Dr. Coleman's knowledge of the health care socioeconomic arena began with membership on the board of Iowa Medical Service (Blue Shield) which named him chairman for a term. Later he was a member of the board of Blue Shield of Florida. Dr. Coleman was a member of the American Medical Association's Professional Standards Review Organization

(PSRO) Advisory Committee, and of the Committee on Health Services Industry for the Wage and Price Board under the Economic Stabilization Act in 1972.

In organized medicine Dr. Coleman's talents have long been highly regarded. He was a delegate to the American Medical Association from Iowa and from Florida after several years as an alternate delegate. The Hillsborough County Medical Association elected him president after he had served on virtually all the important committees of that organization. Recent service as president of the Florida Society of Pathologists was preceded by many important years of committee assignments. He also had a term as president of the Florida Association of Blood Banks. At the national level he was elected president of the College of American Pathologists and later president of the American Association of Blood Banks with many important committee assignments in both organizations.

Dr. Coleman did not confine his activities to organized medicine but participated in the Chamber of Commerce, both in Des Moines and in Tampa. He was a member of the Rotary Club of Tampa and was a director and president of the Gulf Coast Symphony. He served as a member of a Special Committee of the Nation's Health Care Needs of the Chamber of Commerce of the United States. He was a member of the Executive Committee of the Tampa World Trade Council and actively engaged in promoting the concept of business-medicine coalitions in an effort to help stem the tide of rising health care. Recently he was president of the United Way of Greater Tampa, Inc.

Dr. Coleman received numerous awards from medical organizations including the Iowa Medical Society Award of Merit, Distinguished Service Award from the American Society of Clinical Pathologists and the College of American Pathologists, the Greater Tampa Chamber of Commerce President's Award, and the Certificate of Appreciation from the American Medical Association.

Dr. Coleman's activities indicate the far-ranging scope of his interests and accomplishments. A listing of accomplishments fails to do justice to Dr. Coleman, the man. He had a deep interest in virtually everything around him, was willing to listen and provide thoughtful and caring advice to those who sought his counsel.

The Village Presbyterian Church in Tampa was packed for his funeral on June 8. The congregation included relatives, friends and colleagues from all over the country as well as Tampa. Leaders of important medical organizations which had benefited from his services were present to pay their respects to a friend.

Dr. Coleman is survived by his wife, the former Ruth Yvonne Ellzey of Jackson, Mississippi, four children and eight grandchildren. Memorial contributions may be made to the Frank C. Coleman, M.D., Scholarship Fund, University of South Florida College of Medicine, 12901 North 30th Street, Box 2, Tampa, Florida 33612, or to the American Cancer Society.

Sanford A. Mullen, M.D.
Jacksonville

LETTERS & VIEWPOINTS

What Went Wrong With Nursing?

In response to your editorial, "Where have all the nurses gone?" permit me to make a few remarks.

The problem of the shortage of nurses is, in a sense, a complex one and yet if one goes back 50 years in the history of nursing the prodrome was there. However, the so-called "progressive" leaders of the profession and some of the wimpy doctors of medicine, who went along with them just to be nice, placed the inoculum into the nursing profession and it has become a full-grown malignancy today.

Back in 1939, there were a couple of nursing programs that were bragging about keeping their students for four years and turning them loose with a bachelor's degree in nursing. From 1939 to the early 1940s, we had a group of affiliating students at Bellevue Hospital who were so-called degree students. They were above carrying bedpans and urinals, above making beds and giving basic bedside nursing care, because they were going to be supervisors not bedside nurses. They would do the surgical dressings that normally the interns did. Passing out medications was a menial task. They were going to be educators and administrators. How they were going to teach and supervise without ever having had any extensive bedside nursing experience was a mystery they never deigned to explain.

The three-year hospital nurse training programs of the past gave the students a good academic nursing theory background and then in the course of their three years of somewhat rigid and regimented nononsense training, they got excellent experience in bedside nursing—real nursing.

The student nurses of that era were a wholesome, intelligent group who usually lacked funds for a college education and elected the three-year nursing course because it gave them food, lodging, a small stipend, uniforms, sense of security, and a feeling they were entering a worthy and esteemed profession. Believe me, they were not young ladies of weak minds and strong backs. They were bright, energetic, hardworking, highly motivated, energetic, and of high personal integrity. Little by little these three year schools were looked down upon, demeaned and eventually passed out of existence in favor of the "paper" nursing programs that provided bachelor degrees.

It is ironical that the foreign nurses that American hospitals are now seeking to recruit are products of three-year hospital nursing programs — not degree nurses — and they are good bedside nurses.

The problem became aggravated by the fact that nurses have been notoriously underpaid for years for the type of skilled (and dangerous at times) work they do.

Let us go back to the degree nurse. This is a person who spends most of her/his academic time in the classroom on nursing and nonnursing subjects (humanities) to get that bachelor degree in nursing. Yet, this person has a paucity of practical bedside nursing experience before graduation. Students work a few hours a week on the hospital floors, and this is supposed to be adequate experience. Let me cite a real experience. Some university students came on a pediatric floor at 10:00 a.m. The instructor took until 10:30 a.m. to orient them. The children had lunch at 12 noon and then rested until 1:30 p.m. The students left for classes for the day at 2:00 p.m., yet their records showed that they had had four hours of bedside pediatric nursing experience.

To add to this farce, we now have nurses who pride themselves in being "nurse practitioners," nurse midwives (Semmelweis must be turning over in his grave), nurse anesthetists, etc. If they want to do a real good job, why don't they go to medical school? Under the three-year hospital training programs, a few of the brighter, more highly motivated nurses, the hardworking ones, worked evenings, nights, and weekends while working for their bachelor, masters, Ph.D. or M.D. degrees.

To put a Band-Aid on the problem of the bedside nurse shortage, the L.P.N. and the two-year associate degree nurse from the community colleges evolved. These people had limited bedside experience so that the hospital hiring them had to spend a number of months giving them the clinical experience they should have had before they were graduated. Even then they did not equal the quality of the three-year hospital trained nurse. To further compound the problem, there has sprung up a number of "technical" schools where in three to six months they turn out "nurse assistants," nursing technicians, etc., again a person with no great clinical experience.

The solution may be ironical. The hospitals are going abroad to recruit three-year hospital-trained nurses. Return to the three-year hospital training programs; then let the cream of the crop tighten their belts and go after their bachelor, masters, doctoral and M.D. degrees.

The nursing profession, in its attempt to glamorize itself, has committed suicide. Millions of years ago the trilobite taught us a lesson — simple

but hard — a lesson that few have bothered to heed, i.e., that the more complex an organism becomes the more it tends to evolve itself into extinction.

G. Thomas Samartino, M.D., R.N., B.A., M.S. (Retired)
Miami

Reporting of AIDS Cases Mandatory

I received the May issue of the *FMA Journal* recently and have read the excellent articles on AIDS. Such articles are very appropriate, as our practicing physicians need to be better informed concerning this dreadful disease.

Here in North Florida (if not throughout the state) we are faced with a serious under-reporting of AIDS cases by private physicians. On several occasions we have had hospitals report admission of AIDS cases, yet later, when a death certificate on the same patient was filed by the attending physician, no mention of AIDS appeared on such certificate.

I would, therefore, point out that the May "AIDS Issue" of the *FMA Journal* was woefully incomplete in that almost nothing was mentioned in that issue concerning physician responsibility for reporting AIDS cases. As far as I can ascertain, the only mention of reporting was a one-sentence reference in one of the articles.

In order to obtain a complete picture of the disease in our area, and in the state as a whole, and assist in epidemiological studies, private physicians must observe the reporting requirements of Section 381.231, Florida Statutes, and the implementing rules found in Chapter 10D-3, 309B, Florida Administrative Code. I will be the first to admit that the Statute and the Rules are lengthy, fragmented and difficult to understand, but AIDS reporting is compulsory by law with violation of either the law or the Rule constituting a misdemeanor.

I have discussed this matter with Ms. Ronni L. Sanlo, of the Department of Health and Rehabilitative Services' AIDS/ARC Surveillance Office for Northeast Florida, and asked her help in providing a "simplified" summary of AIDS reporting requirements. Ms. Sanlo kindly sent me a compilation labeled "AIDS - Rationale For Reporting." That summary, though relatively simple and easy to read, has not been widely distributed throughout the state.

I am taking the liberty of forwarding three pages of that summary to you with the suggestion that they be reprinted in the *FMA Journal*. I believe that the inclusion of such information would greatly assist practicing physicians in determining when reporting of new AIDS cases is required, and how such reports are to be made.

AIDS - RATIONALE FOR REPORTING

State of Florida Reporting Laws

Section 381.231, Florida Statutes (F.S.) provide that "any attending physician, licensed in Florida to practice medicine, osteopathic medicine, chiropractic, naturopathy, or veterinary medicine, who diagnoses or suspects the existence of a disease communicable among humans or from animals to humans shall immediately report the fact to the Department of Health and Rehabilitative Services (HRS)."

Communicable Disease Control - General - Chapter 10D-3.098, Reporting Requirements for AIDS

(1) Reporting of cases of AIDS is required only by physicians licensed under Chapter 458 or 459, F.S., **who make a diagnosis or treat** a case of AIDS.

(2) The form, Acquired Immunodeficiency Syndrome Confidential Case Report (CDC 50.42A. Rev. 8-87), upon which the AIDS case will be reported shall be furnished by the department (HRS) or the local county public health unit and incorporated by reference into this rule. Identifying information required on the form is:

a. patient's name
b. address
c. telephone number
d. date of birth
e. current vital status
f. sex
g. race
h. residence at onset of illness
i. diagnosing hospital
j. disease
k. method of diagnosis
l. other underlying diseases
m. known causes of reduced resistance
n. social and risk factors
o. laboratory data
p. name and address of physician submitting the report.

(3) The time within which the report must be submitted shall be **within two weeks after diagnosis.** Reports shall be submitted to the local county public health unit which, in turn, shall submit case reports within two weeks to the department.

(4) Any report of the diagnosis of "AIDS" shall be submitted in an envelope sealed with tape which is **plainly marked "Confidential."**

Specific authority 381.031(1)(g)1...381.231, 384.25 F.S.
10D-3.102 Enforcement and Penalties

(1) Any person who does not comply as required by subsection 10D-3.097, 3.098, and 3.099 of this rule shall be fined by the department up to $500 for each offense.

(2) In determining the amount of fine to be levied for a violation as provided in paragraph (1), the following factors shall be considered:

(a) A history of late, infrequent, or non-reporting by each physician or mid-wife who makes a diagnosis of or treats a person with a sexually transmissible disease and each laboratory that performs a test for a sexually transmissible disease which concludes with a positive test.

(b) The severity of the violation, including the probability that transmission of the disease will be spread to other persons or serious harm to the health of any person will result or has resulted.

(c) Actions taken by the physician or mid-wife to correct the violation or to remedy the complaints.

(d) Any previous violations of the physician, mid-wife, or laboratory.

(e) All amounts collected pursuant to this section shall be deposited in the County Public Health Unit Trust Fund.

Specific authority 381.411, 384.34 F.S.

Documentation of unreported cases of AIDS is typically made through death certificate validation, through the surveillance office.

John M. Malone, M.D.
Medical Director
Clay County Health Department
Green Cove Springs

Astrology and the PRO

The recent publicity concerning the running of the U.S. government with the aid of astrology has shed a great deal of light on the problems that my medical colleagues and I have had dealing with the PRO (Peer Review Organization). The PRO employees have obviously taken the example from higher government officials and are using astrology in performing their duties.

For those of you who are not familiar with this government agency, it function thusly:

The U.S. government several years ago decided that health care for the elderly people in the United States was costing too much. The reason for this high cost of health care was doctors treating too many diseases, and not curing the patients fast enough.

The solution to this problem was to establish the PRO. This organization limited the number of diseases to 475, and placed a limit on the amount of time that each disease would last. Once the designated time was up the patient is discharged from the hospital, cured.

This system seemed logical. However, as the system came on line there was another factor introduced which was difficult to follow. This factor was the denial of treatment by the government employee who reviews the chart of the Medicare patient.

An example of this process is as follows. A 65-year-old patient passing blood from her rectum is admitted to the hospital.

An examination reveals that the patient has dark red blood coming from her rectum, her vital signs are stable, and her Hg is 12 grams. The patient is treated with IV fluids and observed. Further evaluation with a gastroscope reveals that the patient has a small duodenal ulcer which has stopped bleeding. The patient is placed on Tagamet and discharged in two days.

Several months later a government employee working for the PRO reviews the chart, determines that this was an unnecessary admission, since these studies and treatment could have been performed as an outpatient.

How did the government employee who never saw the patient, never examined the patient, and has never treated a G.I. bleeder, know that the patient would stop bleeding? The answer is astrology.

Here is how astrology helps to make such a determination. The PRO worker draws an astrology chart for the patient, and the attending physician. Green for that day is favorable. The patient will definitely not rebleed. Yellow means possible continued bleeding. Red means definite bleeding.

If the charts show green, no admission. If the charts show red, then the patient will definitely bleed again. The physician can admit the patient and even alert the O.R. crew since he knows that the patient will continue to bleed. If the charts show yellow, then the physician has to rely on his clinical judgment. If the patient doesn't bleed again, then the admission will be denied.

If astrology is used by government workers to judge a patient's disease process, predict the seriousness of a disease and how long the disease will last, why the big flap over members of the executive branch of government and their wives using astrology?

J.N. Brouillette, M.D.
Winter Park

Ethics in the Legal Profession "Fact or Fiction"

I recently phoned a local radio talk show featuring two Miami attorneys who specialize in accident cases. They use all forms of advertising to obtain as clients recent accident victims. In-person solicitation (telephone, mail) and TV, radio, and newspaper ads are all used extensively. Are these advertising methods ethical?

Clients are routinely referred for medical treatment to one of their "experts." Unnecessary and prolonged treatment results and inflated medical bills occur. Clients are instructed to exaggerate their symptoms when interviewed by an insurance adjuster. These clients are *not* given the opportunity to con-

sult with their own doctor or lawyer.

The attorneys boast that they rarely go to court and are very successful when negotiating settlements with adjusters. The monies are very substantial and permit them to spend hundreds of thousands of dollars annually on advertising.

Who pays for these settlements? *We*, the *taxpayers*, do when we pay *higher* and *higher* insurance premiums.

Disciplinary actions are very rare because the Florida Bar and the Florida Supreme Court sit in judgment. The unethical practices outlined previously are obviously condoned by the Bar and the Court. Is that ethical? Is it right?

Therefore, we urge the Bar and Court:

1. To advise these lawyers to cease and desist from these unethical practices forthwith or lose their licenses.
2. To urge the Florida Legislature to outlaw the practice of lawyers obtaining police accident files and emergency room reports as well.
3. To require lawyers to be licensed by the Department of Professional Regulation as are *all* other professions in Florida.

Until these reforms take place, we must conclude that ethics in the legal profession in Florida is *"fact* and *fiction."*

David J. Lehman, M.D.
Hollywood

Subliminal Message

In the May 1988 issue of the *Journal of the Florida Medical Association*, there is an advertisement for Acyclovir which depicts an attractive young lady seated alone in an outdoor cafe with a coffee cup on the table at which she is seated. The caption "Living in the city is lonely enough. . .with herpes it's like solitary confinement" implies that all friendships lead to sex and if you are prohibited from having intercourse, there is no reason to have friends. I don't believe this is the message you wish to convey. It is tasteless and demeaning. I respectfully request the *FMA Journal* not to accept this ad in future issues.

Wm. P. Douglass, M.D.
Ormond Beach

Editor's Note: The ad in question will be reviewed further and a decision will be made soon on whether to continue running it in future issues. I applaud Dr. Douglass for his sharp eye in detecting the subliminal message of the ad.

'You Can Overcome Hearing Loss'

Actor Richard Dysart, star of drama series, "L.A. Law," urges others to benefit from available hearing help as he did:

Almost 20 million Americans have hearing problems. Fortunately, most of them can now be helped—medically, surgically, or like me, with hearing aids.

If you suspect a hearing loss, or thought nothing could be done about it, consult your family doctor or a hearing care professional in your area. You *can* be helped. Arrange for a hearing check-up today.

For hearing help information, call toll-free Hearing HelpLine—800/EAR WELL. Or write Hearing, Box 1840, Washington, DC 20013.

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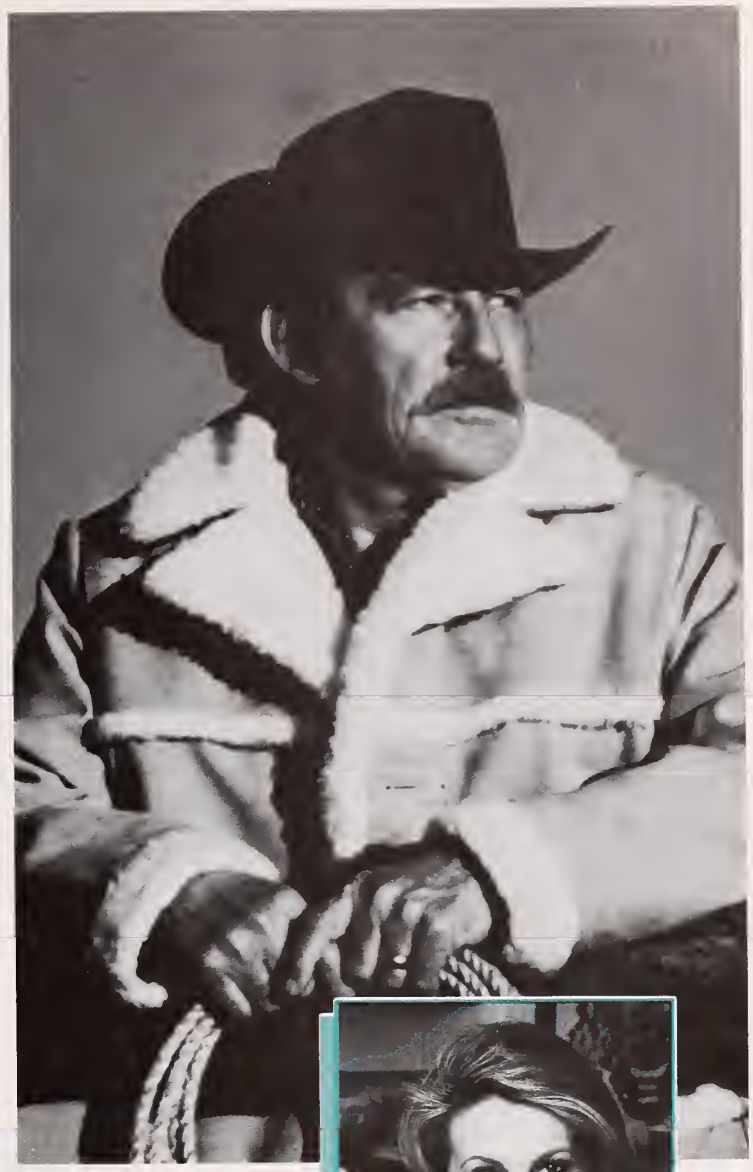

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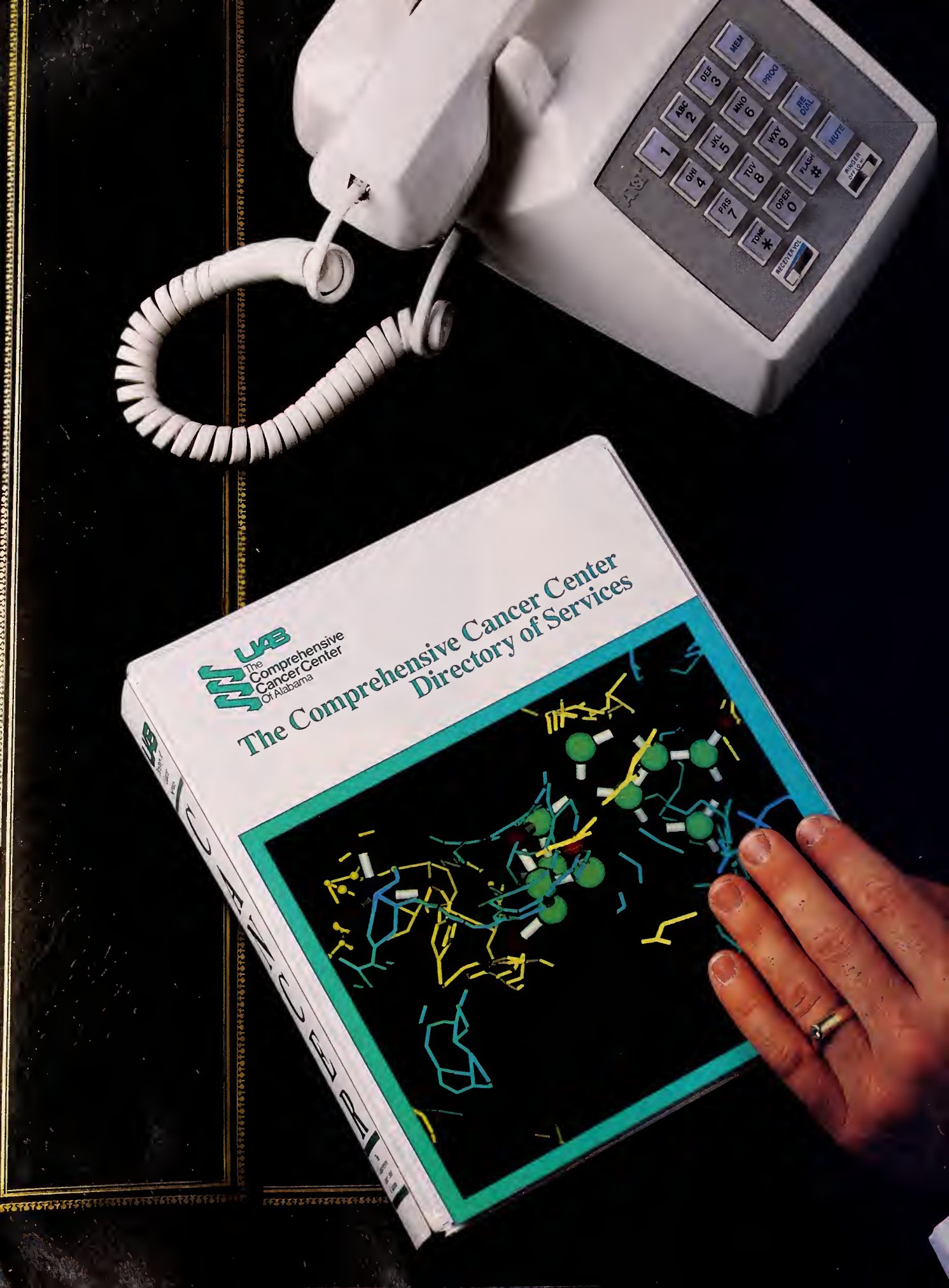
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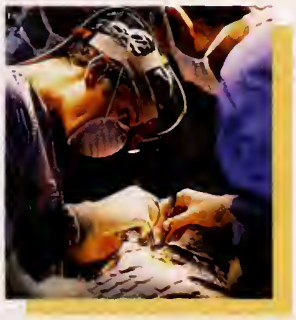

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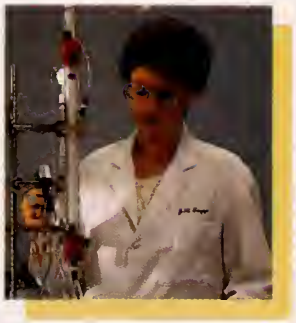

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You'll also find information on physician services; inpatient and outpatient facilities and services; and professional background information, telephone number and major areas of interest of the UAB Medical Staff physicians providing clinical cancer services.

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JULY 1988 • Vol. 75 • No. 7

Computed Tomography of Pulmonary Nodule Using a Standard Reference Chest Phantom

Marc C. Flemming, M.D., and Carlos R. Martinez, M.D.

***ABSTRACT:* Computed tomography (CT) aided with the standard reference chest phantom was used to evaluate 117 patients with pulmonary nodules, comparing the density of the patients' nodule to the reference phantom nodule with all classified as benign or indeterminate. The study yielded 90 proven nodules; of the 72 assessed as indeterminate 57 proved malignant and 15 benign, while of 18 assessed as benign 16 proved benign and 2 malignant. No proven benign nodule was greater than 3.0 cm in size, while the majority of spiculated lesions (81%) and lobulated lesions (86%) proved malignant. Review of plain films of the 16 correctly assessed benign nodules showed no visible calcification in 11 cases. Thin-section CT with reference chest phantom is useful for the detection of calcification in pulmonary nodules and should be part of the diagnostic workup.**

The Authors
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The diagnostic evaluation of the newly discovered pulmonary nodule has long been the subject of controversy and concern to clinicians and radiologists alike. The only widely accepted radiographic criteria for benignancy of a pulmonary nodule are absence of growth for two years or the presence of substantial calcification with a diffuse, central, or laminated pattern of deposition.[1] Often, previous chest radiographs dating back two years or more are not available for comparison and, in many cases, definite calcification is not visible by standard radiographic techniques. Therefore, many benign nodules still require thoracotomy for a final tissue diagnosis.[2]

CT has an inherent higher contrast resolution than plain film radiography and, therefore, should be useful for determining the presence of calcification in nodules not visibly calcified on plain films or tomography. In 1980 Siegelman et al studied 91 radiographically noncalcified pulmonary nodules with CT and found that the majority of proven benign nodules had CT density measurements greater than or equal to 164 Hounsfield units (Hu), presumably due to the presence of diffuse calcification.[3] No malignant lesion was found to be higher than 147 Hu and 164 Hu was proposed as the CT threshold density for benign nodules. Unfortunately, other investigators were unable to reproduce these results. In 1982 Zerhouni et al identified multiple factors responsible for the wide variations in reported CT density measurements, such as type of CT scanner, technique of scanning, reconstruction algorithm, nodule size, position, and surrounding environment.[4] A year later Zerhouni designed and tested a standard reference chest phantom which would take into account the above variable factors and allow comparison of a patient's pulmonary nodule with that of a physical standard reference nodule whose density was derived from extensive clinical trials.[5] Recent follow-up

studies by Siegelman and Zerhouni et al including a cooperative study with ten institutions, of which our institution was one, have reported favorable results using thin-section CT and the reference chest phantom.[6,7]

The primary goal of our study is to report on our experience using CT and the reference chest phantom for the detection of calcification in pulmonary nodules and to evaluate its role in the diagnostic workup of pulmonary nodules.

Materials and methods ● Between August 1983 and March 1987, 117 patients with pulmonary nodules were evaluated with CT and the reference phantom at Tampa General Hospital. The group was made up of 66 males and 51 females with an age range of eight to 88 years, mean 59.4 years.

All patients were examined on a Siemens DR3 CT scanner. Two mm slices were obtained using 125 KV, 480 projections, 520 MA, and a 4 second scan time. Kernel 6 filter of reconstruction and software versions D & E were used.

The reference chest phantom manufactured by Computerized Imaging Reference Systems, Inc., of Norfolk. VA (Fig. 1) is a plastic resin model of a transaxial section of the thorax which is mounted on a velcro-covered support. Two separate sections are supplied which simulate the anatomy at the level of the aortic arch and at the left atrium. The model is also equipped with fat equivalent rings to simulate patient size and has liver and spleen inserts for nodules near the lung bases. The standard reference nodules are actually cylinders of epoxy-resin mixed with calcium carbonate, which vary in diameter from 0.4 cm to 6 cm. The composition of the reference nodules is designed such that the average of the 10 highest pixels in a 1 cm diameter cylinder measures 264 Hu on the Pfizer/ASE 500 scanner, which in effect over estimates the previously clinically determined CT threshold density of benign nodules by 100 Hu.

Initially patients were scanned with 10 mm contiguous slices through the entire thorax. After localizing the pulmonary nodule, 2 mm contiguous sections were obtained through it. The largest diameter of the patient's pulmonary nodule was then determined at lung window setting, i.e., window level of approximately 300 Hu and window width of 1,400 - 2,000 Hu.

Next, a reference nodule of equal diameter was placed in the reference phantom transaxial section best simulating the patient's anatomy at the corresponding level. The phantom was then scanned immediately after the patient using identical technical factors. The CT density of the reference nodule and the patient's nodule was then evaluated by means of visual inspection of individual pixels as they were photographed at a narrow window width, i.e., window width of 2 Hu. The narrow window width

Fig. 1a

Fig. 1b

Fig. 1.—Standard reference chest phantom.
1a: Reference phantom section simulating anatomy at the level of the aortic arch. Phantom is mounted on a velcro backboard for support. A calcium carbonate resin cylinder simulates a right upper lobe pulmonary nodule. A fat equivalent ring fits around the phantom to simulate a larger patient. 1b: Reference phantom section simulating anatomy at the level of the left atrium.

provides an extremely small grey scale and; therefore, all pixels with a density above the window level will be white and all pixels with a density below the window level will be black. Window level is then advanced upward to the CT number at which all pixels in the reference nodule disappeared. If the patient's nodule contained no visible pixels at that setting, it was considered noncalcified and INDETERMINATE (Fig. 2). If, at the same setting, the patient's nodule contained visible contiguous pixels representing approximately 10% or more of the cross-sectional area, then it was considered calcified and BENIGN (Fig. 3). Mean density measurements of the phantom nodules and patient nodules were also calculated using region of interest software available in the viewing console.

Nodules were classified as benign or indeterminate by CT criteria as stated above. Also, nodule

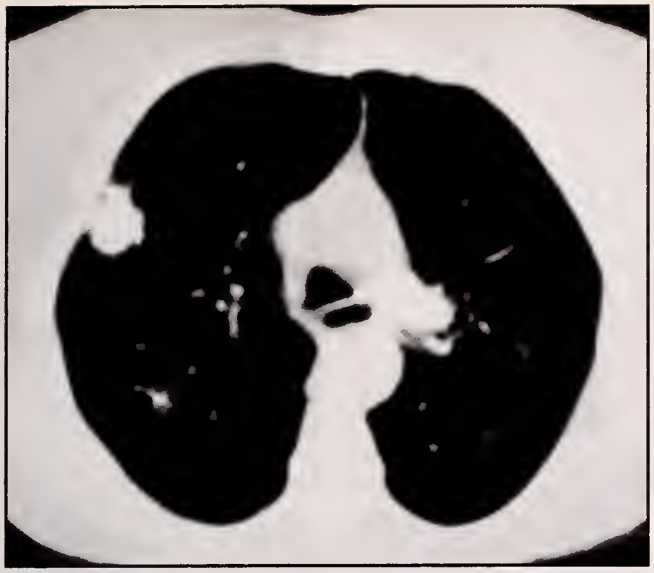

Fig. 2a

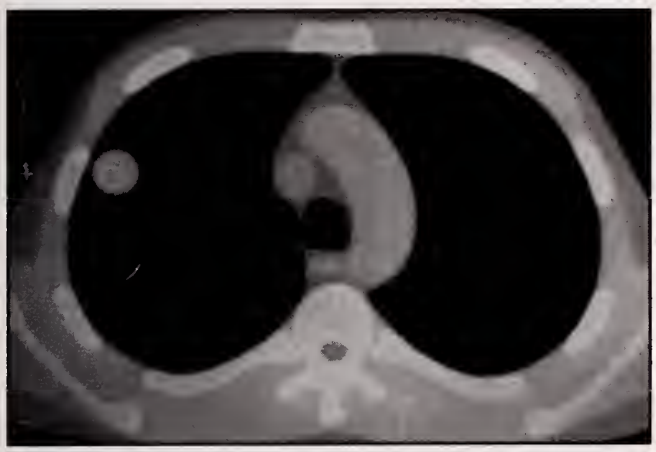

Fig. 2b

Fig. 2c

Fig. 2.—CT indeterminate lesion.
2a: Thin-section CT of patient shows a 2.6 cm spiculated nodule in the right upper lobe. 2b: CT scan of the reference phantom with an equal size reference nodule in place. 2c: Same images as (a) and (b) photographed at a narrow window width of 2 Hu and window level of 130 Hu. Patient scan at top of image and reference phantom at bottom. The patient nodule is not visible, while the reference nodule remains visible. Nodule was classified as indeterminate and later proved to be adenocarcinoma.

size and edge characteristics, i.e., smooth, lobulated, or spiculated, were recorded. For nodules assessed as benign by CT criteria, chest radiographs were assessed for the presence of visible calcification within the nodule in question.

Results • Overall, the study yielded 90 proven pulmonary nodules. All cases of primary lung carcinomas were proven by surgery, percutaneous needle biopsy, or bronchoscopy. Eight of 17 metastatic pulmonary nodules were proven by surgery or needle biopsy, while the remaining nine were presumed metastatic on the basis of clinical evidence and radiographic course. Of the 31 total proven benign nodules, 11 were considered benign by stable radiographs over a two year period, while the remainder were proven by surgical resection (19 of 20) or needle biopsy. Proof of diagnosis could not be obtained in 29 cases (ten with CT assessed benign nodules and 19 with CT assessed indeterminate nodules).

Of the total 90 proven nodules, 72 were assessed as indeterminate by CT criteria, of which 57 proved malignant and 15 proved benign. Eighteen nodules were assessed as benign by CT of which 16 proved benign and two proved malignant (Table 1).

The histologic distribution of the 59 total proven malignant nodules is given in Table 2. Primary bronchogenic carcinomas were approximately twice as frequent as metastatic nodules. The most common primary bronchogenic neoplasm was adenocarcinoma. The 17 metastatic nodules showed a wide variety of histologic types and primary sites; squamous cell carcinomas were the most common (n=8) originating from the cervix, skin, and head and neck. Other types included adenocarcinoma (n=3) from the colon, uterus, and kidney; chondrosarcoma (n=2); melanoma; osteosarcoma; Ewing's sarcoma; and breast. Final outcome or histologic diagnosis of the 31 proven benign nodules is listed in Table 3.

Size correlation of both benign and malignant pulmonary nodules is listed in Table 4. Of proven benign nodules 90% were 2.0 cm or less. Malignant

Table 1.—Data on 90 Proven Pulmonary Nodules.

CT ASSESSMENT	PROVEN MALIGNANT	PROVEN BENIGN
72 Indeterminate	57	15
18 Benign	2	16

Table 2.—Distribution of 59 Proven Malignant Pulmonary Nodules.

HISTOLOGIC TYPE	NUMBER OF CASES
Primary Carcinoma	
Adenocarcinoma	16
Squamous Cell	4
Small Cell	6
Large Cell	5
Alveolar Cell	1
Carcinoid Tumor	4
Undifferentiated or Unspecified	3
Lymphoma	3
Metastases	17

Table 3.—Distribution of 31 Proven Benign Nodules.

OUTCOME OR HISTOLOGIC DIAGNOSIS	NUMBER OF CASES
CLINICAL FOLLOW UP	
No Change During 2 Years Follow Up	11
BIOPSY	
Granuloma	7
Histoplasmosis	2
Tuberculosis	1
Organizing Pneumonia	2
Chronic Inflammation/Scar	3
Infarct	2
Cryptococcosis	1
Bronchogenic Cyst	1
Dirofilaria	1

Table 4.—Size Correlation of Malignant and Benign Pulmonary Nodules.

SIZE (cm)	PROVEN MALIGNANT	PROVEN BENIGN
0.5-1.0	10	17
1.1-1.5	11	6
1.6-2.0	16	5
2.1-2.5	9	2
2.6-3.0	8	1
>3.0	5	0

Table 5.—Edge Characteristics of Pulmonary Nodules.

MALIGNANT	SPICULATED	LOBULATED	SMOOTH
Primary Carcinoma	27	7	1
Carcinoid	0	1	3
Lymphoma	2	1	0
Metastases	5	3	9
BENIGN	8	2	21

nodules were (fairly) evenly distributed throughout the 0.5 - 3.0 cm range with a peak in the 1.6 - 2.0 cm range.

Edge characteristics are listed in Table 5. A majority (77%) of primary bronchogenic carcinomas had spiculated margins. Only one case was smoothly marginated. In contradistinction, a majority of carcinoid tumors (3 of 4) and metastatic nodules (9 of 17) had smooth margins. A majority of benign nodules (21 of 31) had smooth margins, but a substantial minority (8 of 31) were spiculated.

Of the 16 nodules assessed as benign by CT criteria and subsequently proven benign, 11 had no definite calcification on plain chest films, four appeared calcified on plain films, and in one case chest radiographs were not available.

Discussion ● CT densitometry with the aid of the reference chest phantom is useful for the detection of calcification within pulmonary nodules which otherwise would have shown no evidence of calcification on plain radiographs or tomography. Of the 59 total proven malignant nodules, 57 were determined to be noncalcified and were correctly assessed as indeterminate. Of 18 nodules determined to be calcified and, therefore, assessed as benign by CT, 16 were indeed proven to be benign.

A potential source of error is the calcified carcinoma. Histologic-radiographic studies have shown

Fig. 3a

Fig. 3b

Fig. 3c

Fig. 3d

Fig. 3—CT benign nodule.
3a: Chest radiograph of patient shows a right lower lobe pulmonary nodule without visible calcification.
3b: Thin-section CT of patient shows a 1.5 cm round smooth nodule in the right lower lobe.
3c: CT scan of reference phantom with an equal size reference nodule.
3d: Same images as (3b) and (3c) photographed at a narrow window width of 2 Hu and window level of 166 Hu. Patient scan at top of image and reference phantom at bottom. At this setting the reference nodule is not visible, while the patient nodule contains visible contiguous pixels representing greater than 10% of the cross-sectional area of the nodule. Nodule was classified as benign. Nodule was considered benign by stable radiographic appearance over five-year interval.

calcification in 14% of lung cancers.[8] The report of a large cooperative study involving 384 nodules found evidence of some calcification in 7% of lung malignancies studied by CT. However, in ten of 12 the presumed calcification represented less than 10% of the cross-sectional area of the nodule.[7]

Two malignant nodules were incorrectly assessed as benign by CT. Our false negative rate for diagnosis of benign nodules is higher than previously

Fig. 4a

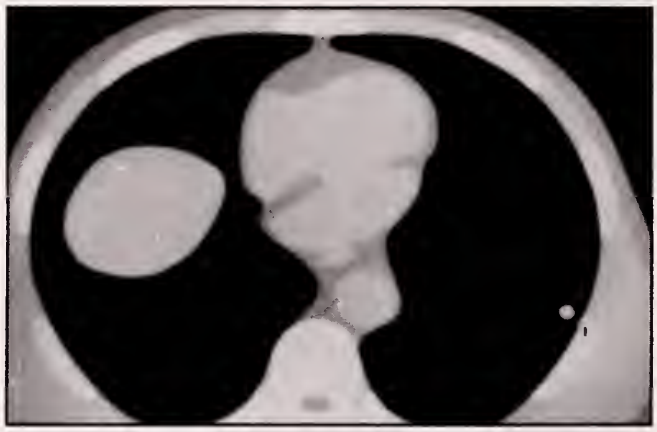

Fig. 4b

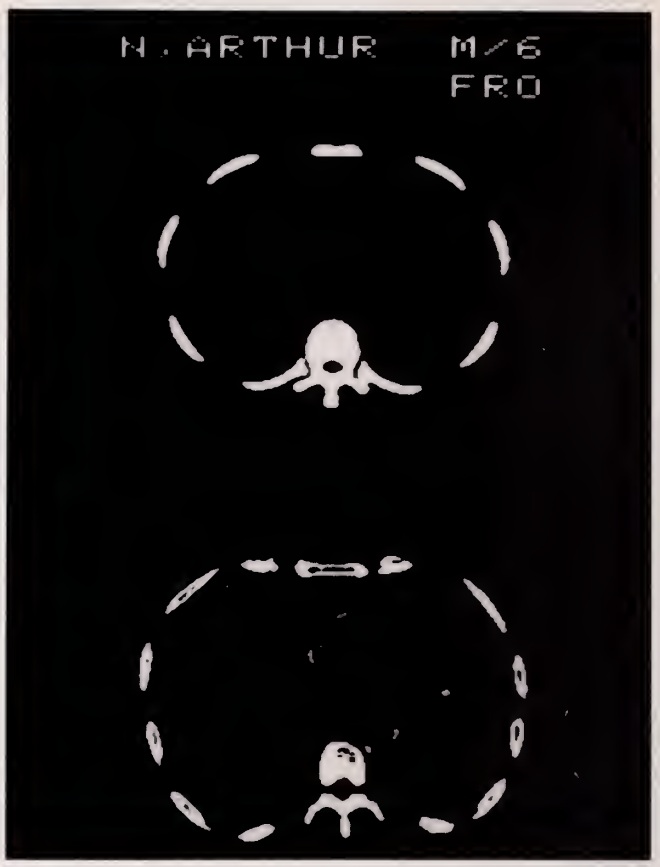

Fig. 4c

Fig. 4.—Example of a nodule incorrectly assessed as benign.
4a: Thin-section CT of patient shows a 9 mm round smooth left lower lobe nodule.
4b: CT scan of reference phantom. Reference nodule used measures about 4 mm, clearly smaller than the corresponding patient nodule.
4c: Same image as (a) and (b) photographed at a narrow window width of 2 Hu and window level of 112 Hu. Reference phantom at top of image and patient at bottom. At this setting, the patient nodule is only a few pixels of greater density than the phantom nodule. Contiguous visible pixels did not exceed 10% of the cross-sectional area and the nodule should have been classified as indeterminate. Also, a reference nodule of equal size to the patient nodule should have been used. Nodule proved to be metastatic adenocarcinoma by surgical resection.

reported.[7] We feel that the two cases were due to errors in interpretation of data, complicated in one case by an error in methodology. One of the incorrectly assessed nodules proved to be a clear cell carcinoma on biopsy. The second case was a 9 mm round, smooth left lower lobe nodule, proven by subsequent thoracotomy and wedge resection at surgery to represent metastatic adenocarcinoma. Neither nodule showed visible calcification on plain films. Retrospectively, each nodule was only minimally denser than the reference nodule. In neither case did the visible contiguous pixels in the patient nodule exceed 10% of the surface area of the nodule, and neither should have been assessed as benign. The 10% surface area requirement helps minimize the effects of partial volume averaging on density measurements.[7] Although we did not use it routinely, software available can display the density measurement in each pixel of a region of interest. This technique could potentially simplify comparison and, perhaps, increase accuracy in comparison of patient and reference nodules in equivocal cases such as these two described previously.

Also, in the second case the reference nodule used was inappropriately smaller (4 mm) than the patient's nodule (9 mm) (Fig. 4). A reference nodule smaller than the patient nodule should not be used for comparison since it may result in an erroneously low density measurement. Therefore, we feel that the incorrect assessment of this nodule as benign was also in part due to a technical error.

These two cases demonstrate that the mere presence of a few pixels in a lung nodule which are more dense than the phantom should not be used as the only criteria for benignancy. Qualitative factors such as distribution of calcification, nodule size, and edge characteristics should also be taken into considera-

tion. It is generally accepted that less than 1% of malignancies will show calcification on standard radiographic examination. Calcification in a lung neoplasm may be dystrophic, may have been present in a pre-existing granuloma or scar and subsequently engulfed by a developin malignancy, or can be seen in metastatic osteosarcoma, chondrosarcoma, thyroid cardinoma, ovarian cystadenocarcinoma, and colloid carcinoma of the breast and GI tract.[10] Focal discrete deposits of calcium favor benignancy while eccentric, noncontiguous deposits should be viewed with suspicion.

Large size is also a factor which militates against benignancy. Ninety percent of proven benign lesions were less than, or equal to, 2.0 cm and no benign lesions were greater than 3.0 cm. The three lesions in the 2.0 to 3.0 cm size range were shown to be inflammatory pseudotumor, cryptococcus, and pulmonary infarction. On the other hand, small size does not decrease the likelihood of malignancy, as ten of 59 malignant nodules were less than 1.0 cm in size. In these cases the increased sensitivity of CT in excluding the presence of calcification may prompt earlier, more aggressive diagnosis and treatment of small carcinomas.

Edge characteristics are also an important factor to be considered. A majority of spiculated lesions (81%) and lobulated lesions (86%) were malignant. Seven of the eight proven benign nodules which demonstrated spiculated margins were assessed as indeterminate by CT. The lesions proved to be infiltrates, chronic inflammation, and granulomatous disease. Large complex, bilobed lesions, or those with spiculations should be assessed with caution. As previously noted, a portion of a complex, spiculated mass may represent an old calcified granuloma or scar, while another portion of the mass may harbor a carcinoma. In retrospect, the clear cell carcinoma incorrectly assessed as benign by CT density measurements also demonstrated spiculated margins and should have been viewed with suspicion. Fifteen of the 16 nodules assessed as benign by CT and subsequently proven benign were round and demonstrated smooth margins. While smooth margins favor a benign diagnosis, it should be noted that a majority of carcinoid tumors and metastatic nodules were also smoothly marginated.

In conclusion, we have found that thin-section CT with the aid of the standardized reference chest phantom is a sensitive indicator of the presence of calcification in pulmonary nodules and, therefore, useful in attempting to determine if a nodule is benign. We feel that CT densitometry should be included in the diganostic evaluation of a patient with a newly discovered pulmonary nodule on a chest radiograph and suggest the following approach to the diagnostic workup; first, obtain old films for comparison. If the nodule has been stable for two years it can be considered likely benign. If it has not been present for two years or has changed, then proceed to fluoroscopy and low kVp spot films. Fluoroscopy aids in exact localization of a nodule. Occasionally "pulmonary" nodules are the result of confluence of shadows, artifacts, pleural thickening, or skin nodules. Low kVp spot films can be helpful for assessment of calcification. If no definite calcification is detected then CT should be the next step. If the nodule is larger than 3.0 cm CT is performed for further assessment of the hila, mediastinum and the remainder of the lungs. If the nodule is smaller than 3.0 cm the thin-section CT with the reference phantom for comparison should be carried out. Nodules assessed as benign by CT should be followed with serial radiographs at three, six, 12, 18, and 24 months. Repeat CT or biopsy is indicated if any change is noted. Nodules assessed as indeterminate by CT generally will require an invasive procedure although a discussion of the relative merits of transthoracic needle biopsy or surgical resection is beyond the scope of this article.

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References

1. Siegelman, S.S.; Stitik, F.P., and Summer, W.R.: Management of Patient with Localized Pulmonary Lesion in Pulmonary System. In: Siegelman, S.S.; Stitik, F.P.; Summer, W.R., (eds.): Practical Approaches to Pulmonary Diagnosis, New York, Grune & Stratton, 1979; pp. 339-358.
2. Keagy, B.A.; Starck, P.J.K.; Murray, G.F., et al: Major Pulmonary Resection for Suspected but Unconfirmed Malignancy, Ann. Thoracic Surg. 38:314-316, 1984.
3. Siegelman, S.S.; Zerhouni, E.A.; Leo, F.P.; Khouri, N.F., and Stitik, F.P.: CT of Solitary Pulmonary Nodule, AJR 135:1-13, 1980.
4. Zerhouni, E.A.; Spivey, J.F.; Morgan, R.H.; Leo, F.P.; Stitik, F.P., and Siegelman, S.S.: Factors Influencing Quantitative CT Measurements of Solitary Pulmonary Nodules, J. Comput. Assist. Tomogr. 6:1075-1087, 1982.
5. Zerhouni, E.A., Boukadoum, M.; Siddiky, M.A., et al: Standard Phantom for Quantitative Analysis of Pulmonary Nodules by Computed Tomography, Radiology 149:767-773, 1983.
6. Siegelman, S.S., et al: Solitary Pulmonary Nodules: CT Assessment, Radiology 160:307-312, 1986.
7. Zerhouni, E.A., et al: CT of Pulmonary Nodule: Cooperative Study, Radiology 160:319-327, 1986.
8. O'Keefe, N.E. Jr.; Good, C.A., and McDonald, J.R.: Calcification in Solitary Nodules of Lung, AJR 77:1023-1033, 1957.
9. Theros, E.G.: Varying Manifestations of Peripheral Pulmonary Neoplasms: Radiologic-Pathologic Correlative Study, AJR 128:893-914, 1977.
10. Felson, B.: Chest Roentgenology, Philadelphia, W.B. Saunders Company, 1973, p. 489.

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Adnexal Torsion: Five-year Experience at Tampa General Hospital

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***ABSTRACT:* Nine patients were admitted to Tampa General Hospital with the proven diagnosis of adnexal torsion during the five years ending April 1, 1987, five on an emergency basis and only two with this primary diagnosis. The patients generally had normal vital signs but were in acute distress from pain. Pelvic masses were palpable in six patients. Operative findings were torsion of the tube and ovary in six patients and isolated tubal torsion in the other three. The masses ranged from 2-15 cm in maximum diameter. One patient was pregnant. The greatest morbidity appeared to be the loss of potentially salvable adnexa.**

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Torsion of the uterine adnexa is an infrequent cause of abdominal pain in women. It is frequently misdiagnosed, producing delay in appropriate therapy and loss of potentially salvable adnexa.

Historically, the initial description of adnexal torsion is attributed to J. Bland Sutton in 1817. Over the past 70 years, there has been a paucity of information regarding this subject. This presentation includes a survey of patients treated for adnexal torsion at Tampa General Hospital over the past five years, and a review of recent literature on the subject.

Material and Methods ● A retrospective analysis of patient records was carried out over the five-year period ending April 1, 1987. Nine patients admitted to Tampa General Hospital during that period subsequently proved to have adnexal torsion.

Results ● The age of the identified patients ranged from 19 to 38 years with a mean of 26.5 years. Seven were Caucasian and two black. Five were admitted on an emergency basis; three were nulliparous. Of the parous patients, three had undergone cesarean delivery including one with a uterine perforation during postpartum dilatation and curettage. Three patients previously had bilateral tubal ligation, and two had been treated for salpingo-oophoritis. One patient had multiple congenital anomalies including an imperforate anus which was repaired in infancy.

Only two patients were admitted with a primary diagnosis of adnexal torsion. Other diagnoses included tubo-ovarian abscess (1), adnexal mass (3), appendicitis (2) and pelvic inflammatory disease (1). An analysis revealed that seven were in the luteal phase of the menstrual cycle and three had a history of irregular uterine bleeding. All patients presented with abdominal pain described typically as crampy or

colicky and five (55%) described prior episodes in the recent past. Four had been recently treated with analgesics and antibiotics. Six (75%) reported nausea and vomiting and three complained of anorexia.

On admission all patients were afebrile and all but one had normal vital signs. She was also found to have acute alcohol intoxication. All patients obviously acutely ill had a mild to moderate leukocytosis without a left shift. Preoperative and postoperative hemoglobin levels were within the normal range.

Physical examination revealed cervical motion tenderness in most patients and a palpable pelvic mass in six. The one pregnant patient had a 16-weeks size uterus and exquisite right lower quadrant tenderness. Sonography in all patients identified a cystic or complex mass separate from the uterus in all but one.

All patients underwent exploratory laparotomy with one having prior diagnostic laparoscopy. Seven patients underwent unilateral salpingo-oophorectomy. One total abdominal hysterectomy with bilateral salpingo-oophorectomy was performed for associated menorrhagia. One patient underwent a unilateral salpingectomy for isolated tubal torsion. Two had the salpingo-oophorectomy performed through a McBurney incision after exploration for presumptive diagnosis of appendicitis revealed right adnexal torsion. Additional procedures included appendectomy (4), extensive lysis of adhesions (3), myomectomy (1), and fimbrioplasty (1).

Findings at the time of surgery were torsion of the fallopian tube and ovary in six patients and isolated tubal torsion in three patients. The right adnexa were involved in six cases and the left in three.

Gross pathologic study revealed masses ranging in size from 2-15 cm in maximum diameter. The three patients with torsion of the oviduct had tubal disease, with a hydrosalpinx identified in two cases, and a large paratubal cyst in the third case. In three patients, both the fallopian tube and ovary were massively enlarged with associated infarction. The pregnant patient had a 8 x 6 cm ovary with a frankly hemorrhagic corpus luteum and multiple, subcapsular, fluid-filled cysts. It is notable that no ovarian neoplasia was found.

Six patients were discharged by the fifth postoperative day. One patient had a prolonged stay due to alcoholic liver disease. Another patient developed legionella pneumonia requiring respiratory support. The pregnant patient had a wound infection and was readmitted for care. She subsequently delivered a healthy, full-term infant by repeat cesarean section.

Discussion ● Adnexal torsion is an uncommon clinical entity. The exact incidence is difficult to determine. A retrospective analysis by Hibbard of emergent gynecologic admissions at the University of Southern California Women's Hospital over a 10-year period revealed adnexal torsion to be the fifth most common pelvic disease encountered.[1] In his study of 3,772 patients requiring emergency surgery, there were 102 cases (2.7%) of adnexal torsion. In addition, 26 patients were diagnosed as having adnexal torsion during elective surgery and 97 patients were admitted with an erroneous diagnosis of torsion.

The majority of patients who present with this entity are in the reproductive age group.[1,2] Approximately 15% of cases occur during infancy and childhood.[3] The differential diagnosis commonly includes ectopic pregnancy, salpingo-oophoritis, appendicitis, adnexal mass, ruptured ovarian cyst, renal stone, acute degeneration of a leiomyoma and distended bladder. This extensive list attests to the difficulty in making an accurate diagnosis. The only univeral, presenting complaint is pelvic pain that is usually acute in onset, developing within 48 hours of presentation and often accompanied by nausea and vomiting. The patient may give a history of previous episodes of pain that resolved spontaneously. It has been estimated that 10-59% of the patients have chronic torsion.[1,2]

Adnexal torsion may involve the fallopian tube, ovary or both, as seen in our study. Isolated torsion of the fallopian tube is usually associated with hydrosalpinx, pyosalpinx or previous tubal ligation (predominately Pomeroy), but may involve a normal tube.[4-6] Interestingly five of our patients had previous pelvic surgery and four had extensive adhesions. Bilateral adnexal torsion, with 15 cases reported worldwide, presents similar to unilateral torsion and may be simultaneous.[6] Autoamputation of the fallopian tube and/or ovary has also been reported secondary to torsion.[7]

The most common predisposing lesion has reportedly varied from a 6 cm cystic adnexal mass[2] to a 10-12 cm nonadherent ovarian neoplasm.[8] In Hibbard's study a benign cystic teratoma was the most common neoplasm to undergo torsion although paraovarian cysts were the lesions with the highest risk for developing torsion. In our study, there were no ovarian neoplasms. Estimates of the frequency of malignancy in torsed adnexa range from 1.5-15%, increasing in postmenopausal patients.[1,2]

Twenty-five percent of cases of adnexal torsion have been reported to occur in pregnancy, predominantly in the early second trimester. The adnexa are often inaccessible to pelvic examination and there may be an atypical location of pain. If the condition is promptly diagnosed and treated, it generally does not interfere with successful completion of the pregnancy.[9,10]

Ovarian hyperstimulation syndrome is associated with a 12% incidence of ovarian torsion. It has been treated conservatively by unwinding the infundibulopelvic ligament but early intervention is necessary to salvage the ovary.[11]

Treatment depends on the age and reproductive status of the patient, presence or absence of malignancy,

and condition of the involved tissues at the time of surgery. If the diagnosis is suspected, selective use of laparoscopy has been advocated.[1] Once the diagnosis is confirmed, immediate laparotomy is imperative to preserve tissue and minimize the risk of rupture. No adnexa were salvaged in our series and certainly the salvage rates in the literature are low, ranging from 5-7%.[1,2] Responsible factors include delay in therapy, difficulty encountered in evaluating viability of tissue at time of surgery and fear of embolism by untwisting the torsed pedicle. Unless a malignancy is involved, consideration should be given to preserving the adnexa in women in the reproductive age group who desire future fertility. It has been suggested that if the tissue appears viable and there is no palpable clot in the vessels, an attempt should be made to untwist the pedicle and suture the lateral pole to the pelvic sidewall or broad ligament. The ovary is then observed for several minutes to assure adequate blood flow.[4] Pulmonary embolism has been reported following detorsion.[5] The risk of this complication is difficult to predict and, therefore, detorsion should probably be approached with extreme caution.

Torsion more frequently involves the right adnexa, with an estimated 3:2 ratio. The degree of torsion has been reported to vary from 180° to six complete turns with the average being two turns.[12]

Mortality and postoperative complications are rare and recovery is usually rapid. The greatest morbidity appears to be the loss of potentially salvable adnexal tissue in a population of women in the reproductive age group. A high index of suspicion together with the selective use of diagnostic laparoscopy may reduce treatment delay. Cautious detorsion in selected cases with careful assessment of tissue for viability is a management option that will have to be highly individualized by experienced clinicians.

References

1. Hibbard, J.D.: Adnexal Torsion, Am. J. Obstet. Gynecol. 152:456-459, 1985.
2. Lee, R.A and Welch, J.S.: Torsion of Uterine Adnexa, Am. J. Obstet. Gynecol. 97:974-977, 1967.
3. Adelman, S.; Benson, C.D., and Hertzler, J.H.: Surgical Lesions of Ovary in Infant and Childhood, Surg. Gynecol. Obstet. 141:219-226, 1975.
4. Blair, C.R.: Torsion of Fallopian Tube, Surg. Gynecol. Obstet. 26:727-730, 1962.
5. Provost, R.W.: Torsion of Normal Fallopian Tube, Obstet. Gynecol. 31:80-81, 1972.
6. Dunniboo, D.R. and Wolff, J.: Bilateral Torsion of Adnexa: Case Report and Review of World Literature, Obstet. Gynecol. 64S-555-595, 1984.
7. Woodruff, J.D. and Pauerstein, C.J.: Fallopian Tube, Williams and Wilkins Company, Baltimore, pp. 253-257, 1969.
8. Nichols, D.H. and Julian, P.J.: Torsion of Adnexa, Clin. Obstet. Gynecol. 28:375-380, 1985.
9. McGowan, L.: Surgical Diseases of Ovary in Pregnancy, Clin. Obstet. Gynecol. 28:843-845, 1983.
10. Chambers, J.T.; Thiagarah, S., and Kitchin, J.: Torsion of Normal Fallopian Tube in Pregnancy, Obstet. Gynecol. 54:487-489, 1979.
11. Hurwitz, A.; Milwidsky, A.; Yagel, S., and Adoni, C.: Early Unwinding of Torsion of Ovarian Cyst as Result of Hyperstimulation Syndrome, Fert. Steril. 43:393-394, 1983.
12. McGowan, L.: Torsion of Cystic or Diseased Adnexal Tissue, Am. J. Obstet. Gynecol. 88:135-136, 1964.

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ARMY RESERVE MEDICAL PROFILE NO.7

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"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

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"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk; and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Regulatory Changes Regarding Physician's Assistant Clinical Practice

Wayne D. Bottom, P.A.-C, M.P.H., and Emilio Echevarria, M.D.

***ABSTRACT:* Significant legislative and regulatory changes regarding the employment and supervision of physician's assistants (PAs) in Florida have been incorporated into the revised Medical Practice Act enacted by the 1986 legislature. These changes include creation of a Physician's Assistant Committee with composition and responsibilities delineated by statute; provision for temporary certification of recent graduates of approved PA programs; elimination of the supervising physician's involvement in the application process for certification; provision for notification of changes in a PA's employment submitted to the Department of Professional Regulation; delineation of grounds for discipline or termination of a PA's certification; clarification of definitions pertaining to supervision of PAs; issue of legal liability for a PA's professional activities; and clarification of tasks that may and may not be performed by a physician's assistant. Review of these changes will clarify physicians' obligations and responsibilities in working with PAs.**

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The sunset of the Medical Practice Act in 1986 resulted in numerous revisions including several significant legislative and regulatory changes that govern the employment and supervision of physician's assistants (PAs) in Florida. These changes are in section 458.347, Florida Statutes, and Chapter 21M, section 17, Florida Administrative Code (hereinafter called the Rules) governing the practice of medicine in Florida. Since regulation of physician's assistants is under the jurisdiction of the Department of Professional Regulation's Board of Medicine, it seems timely to discuss the salient changes in both the statute and rules so that all physicians may understand their obligation and responsibility while working with and supervising PAs.

Regulation of physician's assistants ● A physician's assistant, as defined by statute, is "a person who is a graduate of an approved program or its equivalent or meets standards approved by the Board and is certified to perform medical services delegated by the supervising physician." The inappropriate use of the term *physician's assistant* applied to any individual who has not been properly certified by the Department of Professional Regulation as a certified physician's assistant is a third degree felony, according to Florida Law, and is punishable as such.

In an attempt to refine the regulation of physician's assistants within the state, the legislature has created by statute a Physician's Assistant Committee composed of three graduate PAs, a physician member of the Board of Medicine, and a practicing physician who currently supervises a PA in practice. The statute endows this committee with the responsibility to "review and make recommendations to the Board regarding all matters relating to physician's assistants that come before the Board." The Physician's Assistant Committee is directly responsible to the Board and meets on a regular basis. This committee essentially continues to have the same functions that it executed prior to the 1986 legislation, when the

committee existed as a Board-created committee; the only significant difference is that the committee now has its composition and responsibilities delineated by statute.

Certification of physician's assistants ● The statute provides for temporary certification of graduates of approved PA programs who have been unable to take the national certifying examination because it is given only annually in October. Once an individual has passed the national board examination, his certification as a PA is then converted to a permanent certification which may be renewed biennially through payment of a renewal fee and demonstration of 100 approved hours of continuing medical education.

An important change in the certification process under the new statute and Rules is that the law now provides for certification and credentialling of a PA without requiring that the supervising physician apply for certification to supervise the PA. At the time of the initial certification, PAs will now be required to submit a Physician's Assistant Supervision Data Form [DPR/PA/007(4/87)]. This form requires the PA to list the name, type of practice, and Florida license number of each physician who will supervise him. In addition, the location and address of all practice settings in which he will function must be provided on the same form. Although the physician has no responsibility for completing this form, it would be good practice to require that a copy of the form be submitted to each physician listed, to demonstrate that the PA is in full compliance with the regulation pertaining to this form.

An additional change that has considerably streamlined the process of changing physician employers for PAs is the statutory provision that any certified PA within the state of Florida who changes employment must submit a new Supervision Data Form within 30 days following a change in employment or supervision. The submission of a new form with every change in employer will provide current information on the practice patterns of PAs within the state. Again, it would be advisable for each physician or institution to require that a copy of this form be submitted, for the record, to ensure a PA's compliance with the regulation.

The revised statute specifically states that the Board "may deny, suspend, or place restrictions upon the certification of a physician's assistant if he or the supervising physician has been found guilty of or is being investigated for any act which constitutes a violation of (the law)." In addition, the Rules (21M-17.006) delineate grounds for discipline or termination of certification of a PA. Such grounds include impairment through substance abuse, conviction of a felony related to or affecting the PA's professional competence, or other acts that would constitute violations of Chapter 458 or rules promulgated by the Board pertaining to the practice of a PA.

Physician/PA relationship ● Chapter 21M-17.001 of the Rules governing PAs defines the term *supervising physician* as "the licensed physician or group of physicians assuming responsibility and legal liability for the services rendered by the physician's assistant(s);" likewise, the Rules define the term *alternate supervising physician* as "the licensed physician(s) who is delegated by the supervising physician as responsible for the services rendered by the physician's assistant in the absence of the supervising physician who is in solo practice." It is noteworthy, however, that the Board of Medicine will continue, as in the past, to require one physician to assume the role of primary supervising physician. The current language of the Rules makes this point somewhat confusing.

The responsibility of a physician in supervising a PA has been delineated in statute and Rules in an attempt to establish clear principles that should govern the physician/PA relationship. Rule 21M-17.001(7) defines *responsible supervision* as "the ability of the supervising physician to responsibly exercise control and provide direction over the services of the physician's assistant." It further mandates the physician's periodic review of the PA's performance and requires the "easy availability or physical presence of the supervising physician" in order to exercise supervisory responsibility for the PA.

The statute has made it clear [section (2) (f)] that the easy availability of the physician need not necessarily require the physical presence of the physician. The term *easy availability* is defined as including "the ability to communicate by way of telecommunication" as a means of supervision. The Board has further delineated supervision, in Chapter 21M-17.001 (7) (a) and (b), by defining two terms, direct and indirect supervision, to assist the physician in determining adequate supervision for a particular task or circumstance.

Direct supervision is defined in Rule 21M as "the physical presence of the supervising physician on the premises so that the supervising physician is immediately available to the physician's assistant when needed." The term *indirect supervision* is defined in the Rules as "easy availability of the supervising physician to the physician's assistant, which includes the ability to communicate by telecommunications." The latter term, indirect supervision, is a precarious term and is further defined in Rule 21M to mean that the physician has "reasonable proximity" to the place of practice, such that the physician could physically join the PA to assist in patient management, as necessary, and could, if necessary, provide immediate instructions via telecommunications until such time as the physician's physical presence is possible.

When determining whether direct or indirect supervision of a PA is appropriate, it is incumbent on the physician, as outlined in the Rules and as expressed in the legislative intent of Chapter 458.347, that the physician must consider several important factors,

including: the complexity of the task being delegated; the background, training, and skill of the PA; and the risk to the patient and the reasonable potential for morbidity or mortality related to the task. This places ultimate responsibility on the supervising physician to exercise prudent judgment in determining the type of supervision, either direct or indirect, that is necessary to protect the patient's health and welfare.

The question of legal liability for a PA's activities is addressed in terms of the supervising physician. The statute specifies that "each supervising physician using a physician's assistant is liable for any acts or omissions of the physician's assistant acting under his supervision and control."

PA clinical practice ● In formulating rules to deal with the general principles of a PA's scope of practice, the Board followed the guidelines of the statute which states that "the Board shall adopt by rule the general principles that supervising physicians must use in developing the scope of practice of a physician's assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice setting in which physician's assistants are used." This statutory preamble was reviewed by the Physician's Assistant Committee and the Board of Medicine, and it was recognized that an exhaustive list of tasks that a PA may or may not perform would be an impossible encyclopedia of tasks and procedures, considering that PAs today practice in as many diverse specialties and settings as physicians themselves. Therefore, a suggested list of duties is outlined in the Rules (21M-17.012), but it is definitively stated that the duties performed by a PA are not limited to the tasks specifically outlined in 21M-17.012. It is understood that PAs will evolve in their knowledge and understanding of clinical skills and procedures, under the direction of the supervising physician; the Rules are not meant to prohibit the further education and development of individual PAs but are meant to provide general guidelines to supervising physicians in the use of PAs.

There are certain tasks that the Board has specifically forbidden under indirect supervision; the delegation of these tasks to a PA would require the supervising physician's physical presence on the premises. These tasks are: (1) routine insertion of chest tubes and removal of pacer wires or left atrial monitoring lines; (2) performance of cardiac stress testing; (3) routine insertion of central venous catheters; (4) performance of biopsies (skin, bone marrow) unless seen and approved by the physician; (5) injection of intrathecal medication without prior approval of the physician; (6) excision of skin lesions unless previously seen and approved by the supervising physician; and (7) interpretation of laboratory tests, x-ray studies, and EKGs without the supervising physician's interpretation and final review.

There are four specifically forbidden tasks that cannot be delegated at all. Each of these tasks requires some explanation. The first is prescribing, by which is meant that a PA may not write and sign a prescription to be dispensed by a pharmacist. This does not forbid, however, a PA from calling a prescription into a pharmacy under the orders of his supervising physician. Likewise, it does not forbid a supervising physician from having a PA write orders in a hospital record, in accordance with the hospital's bylaws and regulations, provided that the orders are countersigned within a reasonable length of time, as specified by hospital bylaws and regulations. It is important to note the distinction between ordering as a function of physician delegation and initiating a treatment regimen by writing a prescription. It is always understood that any orders written on a hospital record by the PA represent the explicit instructions and wishes of the physician. The usual safeguard that allows nurses and pharmacists within the hospital setting to question any inappropriate order continues to exist.

A second forbidden delegation is final diagnosis. This is understood to mean that a PA may not see, diagnose, and treat a patient without the physician's review. There are numerous ways of being in compliance with this rule, ensuring that the physician retain the responsibility of final diagnosis. For example, the physician could see the patient physically and confirm the findings of the PA; likewise, the rule that "all tasks and procedures performed by the PA must be documented in the appropriate medical record and the supervising physician must review and sign the physician's assistant's record" provides another mechanism for assuring that final diagnosis is in fact the purview of the physician and not the PA. By reviewing the record the physician is taking full legal and professional responsibility for the tasks and procedures as outlined in a given patient's medical record. While this may seem a trivial distinction, it in fact epitomizes the very essence of the physician/PA relationship. It is not the intent of the PA profession to replace physicians. The profession exists "to encourage more effective utilization of the skills of physicians or groups of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare." The PA's dependency on the physician's supervision is the hallmark of the success of the physician/PA team. It is, therefore, in keeping with the full understanding of the physician/PA relationship to leave the ultimate responsibility for final diagnosis in the hands of the physician.

A third task that may not be delegated is the dispensing of medications. While a PA may administer medications at the direction of his physician (as do nurses and other technicians), a PA may never hand either sample medications or prescriptions to patients unless the physician is physically standing in the presence of both the patient and the PA. It becomes obvious, if the Pharmacy Practice Act is interpreted

in this way, that the dispensing of sample medications or other prepackaged medications by PAs becomes an all but useless delegated task since the physician must remain physically present if such activity is to occur.

Finally, a PA may not be delegated the administration of general, spinal, or epidural anesthesia unless the PA is a graduate of an anesthesiology assistant program and has been certified by the Board of Medicine to perform such tasks. This does not, however, include local infiltrative anesthetics or regional blocks, as long as the PA is experienced and knowledgeable, as determined by his supervising physician.

A final stipulation in the Rules, regarding a PA's scope of practice in medical emergencies, specifies that "the physician's assistant will act on behalf of the supervising physician to maintain life support until a licensed physician arrives to manage the patient" [21M-17.012(5)]. This provision is in keeping with the Good Samaritan provision that allows a practitioner to act within his knowledge and skills to sustain life.

Conclusion ● Physician's assistants are now certified and approved by the Board of Medicine to practice as physician's assistant under the supervision of all physicians listed on the Physician's Assistant Supervision Data Form and filed with the Department of Professional Regulation, with the proviso that one physician is identified as the primary supervising physician. The certification and renewal of certification of PAs are the complete responsibility of PAs; under the new statute and regulations there are no fees or paperwork required of physicians. It is incumbent on all physicians working with PAs to read carefully Chapter 21M, section 17, which outlines all the rules and regulations governing the practice of physician's assistants as well as Chapter 458.347 of the Florida Statutes outlining the current legislation governing the creation and regulation of PAs in the state of Florida.

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A Survey of University Students' AIDS-Related Knowledge and Attitudes

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***ABSTRACT:* Because there is presently no known cure for AIDS, the focus of most efforts to ameliorate this disease has been on prevention. Prevention through education seems to be the most reasonable approach. This report summarizes a survey of college students' AIDS-related knowledge and educational efforts. Student errors regarding knowledge components are discussed and attitudes toward the disease are analyzed. Suggestions are made for a more active role on the part of the health care community.**

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The U.S. Public Health Service has labeled acquired immunodeficiency syndrome — AIDS — "the most important public health problem facing us today."[1] Almost 32,000 Americans have been reported with AIDS; about half have died. There may be as many as 1.5 million additional Americans already infected with the virus who may, therefore, be in the process of transmitting it to others. In 1985 AIDS moved to 11th on the list of causes of years of potential life lost[1]. Yet, in spite of its seriousness and the attention garnered from governmental, media, and other sources, AIDS has remained in at least a partial shroud of misinformation which has exacerbated the problems associated with it.

The media have been responsible for providing the greatest amount of information for Americans of all ages about AIDS.[2,3] However, the media have also been cited for distorting information and using sensationalism which have led to misleading and even dangerous ideas. For instance, in one public poll,[4] one third of the national sample of adults polled (N=1512) felt it was unsafe to associate with someone who had AIDS even if there was no physical contact. In another study, 47% believed it was possible to contract AIDS by drinking from a glass that had been used by someone with AIDS.[5] There have been instances of students and parents boycotting schools due to the suspected presence of an AIDS victim.

On the other hand, a Washington Post-ABC News Poll found that three of four Americans were not personally afraid of contracting AIDS and were not taking special precautions to avoid exposure;[4] and NBC-Wall Street Journal poll found that 92% of respondents said they had not made any changes in the way they conducted their lives.[6] There seems to be a sense of denial in the attitudes of many Americans, especially among heterosexually-oriented individuals, which has not been affected by the information available to the general public. For many, including the young, AIDS is seen as a problem limited to "gays and poor

minority-group members."[6] However, although the number of cases of AIDS is currently small among the heterosexual population, there is evidence that it is growing in higher proportions within this group and that infection is passed from women to men as well as in the opposite direction.[7]

Increasing knowledge about high-risk behaviors seems to be the prevalent recommendation for prevention among virtually all groups of Americans, including youth. Yet, the few studies which have been conducted on students have shown that many are ignorant of the important information surrounding the spread of this disease. DiClemente et al[8] found that only 60% of the 1,326 students aged 14-18 surveyed knew that "use of a condom during sexual intercourse may lower risk of getting AIDS." Approximately one of three believed that AIDS could be spread by using a victim's personal belongings; about the same number thought that casual contact, i.e., shaking hands, could result in contracting the disease. Only one quarter knew that there was no new vaccine for treating AIDS; two thirds believed AIDS could be cured if treated early. Another study of high school students from the Midwest found a similar lack of accurate knowledge among youth. Fifty percent or more of the students in this study did not know which persons were at higher risk for getting AIDS, nor what happened to people who contracted the disease, nor how to detect AIDS, nor whether it is transmissible.[3]

The purpose of this study was to ascertain the level of knowledge concerning AIDS of college students, presumably a more educated and more sexually active group.

Methodology ● This study was conducted among students in introductory health science classes in June 1987 at a major state supported university in Florida. The survey was part of a nationwide effort to collect student's knowledge, attitudes and behaviors related to AIDS. The instrument used was designed by DiClemente and colleagues in their research with adolescents in San Francisco.

The survey instrument consisted of a series of knowledge statements followed by a series of attitudinal and behavioral statements. The subjects were asked to respond to the knowledge statements by indicating one of three choices: agree, disagree, and don't know. The attitudinal statements required subjects to indicate whether they strongly agreed, disagreed or strongly disagreed.

Students were asked to complete the survey instrument during the first week of classes in an effort to reduce bias which might be formed by taking the class. There were a total of 104 responses to the survey of which 70% were female. The ages of the respondents ranged from 18-40, although almost two thirds of the respondents were aged 19-21. Seventy-eight percent of the sample were white. There were a total of 33 different majors represented among the students surveyed, indicating that this was a university-wide sample.

Results ● The results of this survey indicate the college students surveyed have some knowledge regarding

Table 1.—Responses for Knowledge Statements.

STATEMENT	RESPONSE (%)		
	Agree	Disagree	Don't Know
Women with AIDS can infect men	94	0	6
Men with AIDS can infect women	97	0	3
You can get AIDS by sharing clothing	3	96	5
You can get AIDS from kissing	29	53	17
You can get AIDS from vaginal intercourse	96	0	4
You can get AIDS from anal sex	89	0	11
You can get AIDS from oral sex	71	11	18
A person can be infected with the AIDS virus and not have symptoms	84	4	12
Sneezing and coughing can spread the disease	6	65	29
You can get AIDS from swimming pools	3	78	19
Sharing a drinking glass can spread AIDS	16	61	23
You can get AIDS from a blood transfusion	99	0	1
Almost all homosexual men have AIDS	9	65	26
People with AIDS usually do not die from the disease	1	96	3
AIDS is caused by the same virus that causes herpes	0	63	37
You can get AIDS by shaking hands or hugging someone who is infected	1	89	10
You can get AIDS from someone who is infected but doesn't have any symptoms	92	2	5
You can get AIDS by sharing needles with drug users who are infected	98	1	1
A positive blood test for the AIDS virus means that you have AIDS	34	41	25
You can get AIDS by donating blood	17	69	14
Many gay women have the AIDS virus	19	28	53

the transmission of the disease (Table 1). For example, over 95% of the students indicated correct responses to the statements regarding transmission by sharing needles with infected persons, blood transfusions, and vaginal intercourse. A similar percentage knew that men with the disease could infect women.

There were, however, several disconcerting responses regarding transmission. While kissing has not been identified as a route of transmission for AIDS, 29% of those surveyed indicated they thought it was, and 17% said they did not know. In addition, only 65% of the respondents answered correctly regarding transmission by sneezing and coughing. This finding concurs with findings of other surveys regarding knowledge pertaining to kissing and casual contact as a means of transmission. For example, in a recent CBS poll, 32% of the respondents thought it was possible to catch the disease by kissing, and a recent Harris poll revealed that more than 50% of those polled believed one could contract AIDS from casual contact.

Additionally, there was some error regarding knowledge of diagnosis of AIDS. Thirty-four percent of the respondents incorrectly indicated that a positive blood test meant the individual had AIDS. Perhaps the most disturbing misconception reflected in the survey was the response to the statement regarding transmission of AIDS by blood donation. Only 69% of the students responding correctly indicated that AIDS was not transmitted by donating blood.

In accordance with other studies, the young people in this survey relied on the media as their primary source of information regarding AIDS. The major source reported was television (62%), followed by magazines (17%) and newspapers (9%). A related finding reinforcing other studies was the lack of information being disseminated through health professionals and schools; neither was cited as a primary source of information by these young adults.

As might be expected, the attitudinal questions reflected the consequences of the misconceptions cited (Table 2). Fully 66% percent of the students agreed or strongly agreed that they were afraid of getting AIDS. As an expansion of this statement, respondents were asked to indicate how worried they were about getting sexually transmitted diseases, including AIDS. Fifty percent of the respondents indicated they were highly worried about contracting AIDS as compared to 29% and 36% reporting to be highly worried about getting gonorrhea and herpes respectively (Table 3).

Table 2.—Responses for Attitudes Statements About AIDS.

STATEMENT	RESPONSE (%)			
	SA	A	D	SD
AIDS is not as big a problem as the media suggests	0	6	40	53
It is important that students learn about AIDS in classes taught at this college	59	44	1	0
I know enough to protect myself from the AIDS virus	27	47	24	1
AIDS will not spread to the general population	3	48	48	0
I have a good understanding of how AIDS is spread	16	52	27	5
People are more concerned about AIDS than is necessary	0	4	45	9
I would feel comfortable asking someone about their past sex partners before I had sex with them	21	49	24	4
I am afraid of getting AIDS	35	31	27	7
College students with AIDS should be allowed to attend class	9	56	26	6

Table 3.—Student's Response to Worry Index of Several Sexually Transmitted Diseases by Percent.

DISEASE	High Worry Percent	Med. Worry Percent	Low Worry Percent
AIDS	50	11	38
Herpes	44	22	42
Gonorrhea	38	25	47
PID	30	19	43
Chlamydia	24	23	45

Discussion ● The findings from this survey support the need for more vigorous attempts to educate the American population about AIDS. A recent poll by the Los Angeles Times showed a strong correlation between lack of knowledge of AIDS and fear of the disease.[9] While many of the respondents were knowledgeable regarding some aspects of AIDS, gaps in knowledge do exist, particularly pertaining to disease transmission. Additionally, while fear of AIDS as a potentially life-threatening disease may be somewhat justified for the population studied, when compared with other sexually transmitted disease in relation to actual risk of acquisition, the fear seems somewhat overstated. For example, chlamydia is the most common STD among the heterosexual population,[10] yet respondents to this survey worried least

about contracting it. This reflects a need for individuals to learn to differentiate between severity of a disease and susceptibility to that disease. Finally, the public needs to know the difference between preventive health behaviors and those which have no public health justification but which may be unduly discriminatory.

Although schools, physicians, and public health agencies may be more reliable sources of information, results from this survey confirm that the mass media continue to be the main source of AIDS information for the general population. The limitations of this approach have been mentioned previously. It would be extremely beneficial, therefore, for physicians and other health care professionals to assume a more active role in assisting the media to disseminate accurate information in order to allay fears and to reinforce those beliefs and behaviors which will deter the spread of this lethal disease.

References

1. Information/Education Plan to Prevent and Control AIDS in the United States, U.S. Public Health Service, USDHHS, 1987 (March).
2. Simkins, L. and Kushner, A.: Attitudes Toward AIDS, Herpes II, and Toxic Shock Syndrome: Two Years Later, Psych. Rep. 59: 883-891, 1986.
3. Price, J.; Desmond, S., and Kukula, G.: High School Students' Perceptions and Misperceptions of AIDS, J. Sch. Health 55:107-109, 1985.
4. New Poll Shows Most Americans Concerned About AIDS, Kansas City Times 118:A-17, 1985 (Sept. 26).
5. Reed, S.: AIDS in the Schools. A Special Report, Phi Del. Kap. 67:494-498, 1986.
6. AIDS: A Growing Threat: Time:40-47, 1985 (Aug. 12).
7. Francis, D. and Chin, J.: Prevention of Acquired Immunodeficiency Syndrome in United States, JAMA 257:1357-1366, 1987.
8. DiClemente, R.; Zorn, J., and Temoshok, L: Adolescents and AIDS: A Survey of Knowledge, Attitudes and Beliefs about AIDS in San Francisco, Am. J. Pub. Health 76:1443-1445, 1986.
9. Price, J.: AIDS, the Schools, and Policy Issues, J. Sch. Health 56:137-140, 1986.
10. Hales, D. and Williams, B.: Invitation to Health, Menlo Park: Benjamin/Cummings, 1986.

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New & Dynamic Concepts in Pain Management

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AGENDA

8:00-8:15	Introduction/Concepts of Pain Management — Measuring Pain	Dr. J. Green, M.D. *Neurologist*
8:15-8:45	Anatomy & Physiology of Pain	Dr. A. Bar-Sela, M.D. *Physiatrist*
8:45-9:10	Pharmacology of Opiods & Methadone — Addiction	Dr. Greg Poff *Pharm. D.*
9:10-9:45	Multi-Disciplinary Approach to Pain	Dr. A. Bar-Sela, M.D. *Physiatrist*
9:45-10:00	Break	
10:00-10:30	Chronic Back Pain Therapy	Dr. J. Green, M.D. *Neurologist*
10:30-11:00	Malignant Pain Therapy	Dr. L. Green, M.D. *Oncologist*
11:00-11:30	Psychological Aspects of Chronic Pain	Dr. L. Lucas, Ph.D. *Psychologist*
11:30-11:45	Training Resources on Pain Management	Dr. S. Hickey, M.D. *Fellow in Pain Medicine* *University of Pittsburg* *School of Medicine*
11:45-1:00	Lunch	
1:00-1:30	Trigeminal Neuralgia	Dr. S. Hickey, M.D. *Fellow in Pain Medicine* *University of Pittsburg* *School of Medicine*
1:30-2:00	Round Table Discussion — Management of Chronic Pain	Dr. A. Bar-Sela, M.D. Dr. J. Green, M.D. Dr. S. Hickey, M.D. Dr. L. Lucas, Ph.D.
2:00-2:30	Physiology of Sleep, Sleep Laboratories	Dr. C. Leon-Barth, M.D. *Neurologist*
2:30-3:00	Proper Prescribing for Insomnia	Dr. J. Green, M.D. *Neurologist*
3:00-3:30	Break	
3:30-4:00	Local & Regional Blocks in Pain Management	Dr. John Kruse, M.D. *Anesthesiologist*
4:00-5:00	Clinical Case Presentations Bring your own difficult cases	Seminar Faculty

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Economic Stresses of AIDS: Lessons for the United States and Florida

The dimension of the economic blight inflicted upon the United States by the acquired immunodeficiency syndrome (AIDS) is coming into focus. Expert opinions oscillate from a fiscally trivial smudge on the annual gross national product to that of economic depredation.

Since the majority of people with AIDS have no medical insurance, the cost of their care will be borne by the general taxpayer. It is important, therefore, to review the present and projected financial burden that will be imposed upon society. This article examines the issue from the national and Florida perspectives in order to determine if policymakers and the health care industry are about to tumble toward disaster or have choreographed a reasonable long-term plan to manage the financial impact of AIDS.

AIDS: Human costs of the epidemic ● As of May 2, 1988, 60,776 cases of AIDS had been reported in the United States from initiation of the outbreak in about 1980, 4,424 in Florida. The number of reported cases has been doubling every 15 months. The Centers for Diseases Control (CDC) estimates that 30-50 times as many people are infected with the HIV-1 virus, which causes AIDS, than now have the disease.[1] Current data indicate that AIDS will develop in 30-50% of infected but currently well individuals. New York, California and Florida report the greatest number of cases; most are concentrated in large urban centers such as New York City, San Francisco, Los Angeles, Houston, Washington, D.C., and Miami.

The case/fatality ratio since 1980 is 56%. Recent studies, however, demonstrate that 100% of AIDS patients will die from the disease unless some cure is found. The mean survival time from diagnosis to death is 16 months. Ninety percent of individuals have an opportunistic infection; 62% acquire pneumocystic carinii pneumonia and 28% some other unusual infection. Ten percent suffer Kaposi's sarcoma.

Extrapolations of the slopes of the curves that describe the increase in the number of reported cases since 1984 suggest that the total number of cases will quadruple to 270,000 by 1991 (Fig. 1); 32,000 of these will have occurred in Florida. Projecting beyond 1991 is scientifically unreasonable because we have no idea of the impact of new treatments or the effects of educational and/or possible vaccination programs upon future acquisition of the virus. The incubation period between infection and appearance of active disease exceeds seven years; if half the currently estimated number of 1.5-3.0 million infected persons develop the illness then a minimum of 750,000 to 1.5 million cases will be observed before the middle of the next decade.

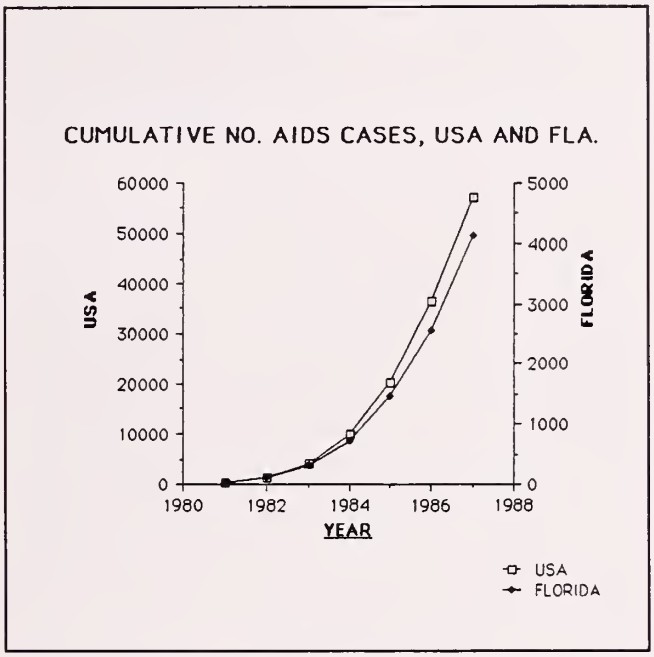

Fig. 1.—Cumulative numbers of patients that have been reported to the Centers for Disease Control with a diagnosis of acquired immune deficiency symdrome. Curves for both the United States and Florida are shown; the ordinate for the U.S.A. cases is on the left and that for Florida on the right. Not seen is that the relative rate of increase is actually slowing, i.e., although the rate of cumulative cases was doubling every year between 1981 and 1986, this rate has recently slowed.

The pattern of the AIDS epidemic in Florida

resembles that of the remainder of the United States. The disease is asymmetrically distributed about the state and concentrated in a small number of highly populated, urban areas with no cases appearing in other areas. Dade, Broward and Palm Beach Counties have reported the largest number. The highest incidence has occurred in Monroe County (188 cases/100,000 population) followed by 102 for Dade, 79 for Broward and 78 for Palm Beach. The incidence for the entire state is 44 cases/100,000 but the range is very broad, varying from zero cases in 11 counties to the 188 figure for Monroe. The median is 10 cases/100,000 population. Nearly two thirds of the cases appear in adult, homosexual or bisexual males. Intravenous drug abuse accounts for 14% of cases. Five percent have appeared in individuals with none of the known risk factors, i.e., drug abuse, male homosexuality, hemophilia, or heterosexual contact with a known infected person. In 1987, 1,568 new cases were reported, increasing to a total of 4,424 cases in this state since 1980. Sixty-one percent of the affected individuals seen in Florida have died.

AIDS: Economic costs of the epidemic ● Several factors must be examined when estimating the total cost of AIDS to American society: (1) direct costs of medical care to the patients; (2) costs of serological testing and replacement of contaminated lots of the blood supply; (3) costs of research; (4) costs of educational programs; (5) indirect costs of lost wages of the patient and the lost economic productivity of both the patients and other members of society such as family members, friends and volunteers who provide home health care to affected people. We will examine some of these costs.

Personal, Direct Costs of AIDS

Two and one-half years have passed since appearance of the initial study that provided some estimate of the costs of medical care for the average AIDS patient. That study by Hardy et al[2] estimated that each AIDS victim would consume $168,000 of medical care. The application of that figure to the entire AIDS population would indicate that the total cumulative costs of direct medical care for AIDS patients would exceed $45 billion by the end of 1991. That study was criticized because it heavily weighed its estimates with the high costs for hospitalization that occurred in New York City. Since that initial report, other studies have provided a range of costs from $43,000 to $115,000 per patient for a cumulative total of $11.7-$31 billion by the end of 1991 (all numbers are expressed in 1986 dollars).

Scitovsky and Rice[3-5] estimated the annual costs for hospitalization of AIDS victims for the U.S. as a whole to range from $16,354 to $52,250 per case and outpatient charges an additional $2,000 to $4,000 per case. Each case in their study would require a total of 22 to 55 days of inhospital care. Bloom and Carliner[6] summarized the various estimates of the costs for the treatment of AIDS and concluded that the average cost per patient will not exceed $80,000 by 1991, an amount similar to treating other serious illnesses. The total cumulative cost of treating AIDS patients from 1980 to 1991 has been estimated by these authors to not exceed $21.6 billion. However, the data from each of these studies assumed that the case-fatality ratios and the survival times of future AIDS cases would continue along current trend lines. We know that treatments, such as AZT, will reduce the one year mortality from 50% to 10%; we do not know if this increased longevity will increase or reduce the long-term costs of treating AIDS patients.

Table 1. — Projected numbers of cumulative totals of patients, prevalence of number of patients alive at any time during the year, costs per patient, and total costs each year to be expended on Florida AIDS victims for direct medical care, 1988-1991.

Year	Cumulative Number Patients	Prevalence	Direct Personal $ Cost/ Patient	Total Direct Personal Costs ($ Millions)
1988	6,205	4,715	44,208	208
1989	11,016	7,931	47,965	381
1990	19,566	13,500	52,042	703
1991	34,727	22,225	56,466	1,255

Table I shows projection of the cumulative total number of cases in Florida from 1988 through 1991, direct medical care costs expressed in current dollars per case, prevalence of cases, i.e., number of patients with the disease alive during that year, and total costs of direct medical care for AIDS victims for each year. These projections indicate that the cost of care of AIDS patients in Florida for 1988 will be about $208 million; by 1991 that cost will have increased to $1.25 billion.[6]

Other, Nonpersonal Cost of AIDS

In addition to the costs of direct medical care for the AIDS patient there are other costs attributable to the presence of the disease in American society. These include research, blood screening and replacement of contaminated blood supply, and health education, information and similar support services. The 1988 federal budget for AIDS research is $930 million. The costs of other research in unknown. In 1988 the costs of screening the blood supply and replacing contaminated units of blood will exceed $300 million; the estimated costs of health education and information services is over $350 million. Scitovsky and Rice[3-5] expect that by 1991 the U.S. cost for research will be

$1.163 billion; for blood screening and replacement $930 million, and for health education and information services $233 million. These expenses will add an additional $25,500 to the cost of care of each AIDS patient in 1991. These extra charges per patient will increase the total cost of treating AIDS in Florida in 1991 by another $566 million.

Indirect Costs of AIDS

The economic drain that AIDS imposes on American society is not contained in these figures. The expenses for medical care, research, education, and the protection of the blood supply will amount to less than 2% of the total American health care budget by the end of 1991. The major expense is the cost of lost productivity and early mortality imposed by the disease. These indirect costs exceed direct expenditures nearly five fold. For instance, in 1986 the cost to society of lost economic productivity due to premature death and disability was approximately $3 billion while the direct cost of treating the AIDS patients in the USA was slightly more than $600 million.[3-5] In 1991 the loss of gross national product from disability, decreased productivity and early mortality from AIDS is estimated to be $55 billion while that for medical care will be about $11 billion. Thus nearly 85% of the costs of AIDS is due to these indirect costs from lost productivity. These costs are higher per person than those of cancer, stroke or heart disease due to the fact that AIDS attacks younger individuals who have a much larger expected future earnings potential than do older patients. The expected lifetime earnings of a healthy 29-year-old male is $727,000; this is lost to society if he dies at age 29. In contrast the expected future earnings of a 67-year-old man is about $30,000; if this man suffers a permanently incapacitating stroke, society will lose much less dollar productivity from him than it will from the young AIDS patient.

Who bears the expenses of AIDS? ● The Health Care Finance Administration estimates that 40% of AIDS patients are on Medicaid while 1% are covered by Medicare. In New York City an estimated 70% of infected individuals are covered by Medicaid, 1% by Medicare, 6% by Blue Cross/Blue Shield, and 1% by private insurance. The majority of the cost is borne by the hospitals, health care providers, patients, their families and volunteers. Hospitals will bear a major burden of providing care to AIDS patients. It is estimated that by 1991 AIDS patients will occupy 2% of all hospital beds in the U.S.A. and consume 3% of total hospital costs. In major urban areas, such as San Francisco, AIDS victims will occupy 12.4% of the beds and consume 16.7% of the hospital budgets in 1991.

The state government of Florida has responded partially to needs of the AIDS epidemic. It has allotted $23,850,435 for patient care, educational awareness, AIDS network evaluation programs in south Florida, and operations of the State Health Office, district offices, and state laboratories. This number compares to the total of nearly $300 million ($208 million for direct patient care and $85 million for research, education, and blood banking costs) that will be consumed by the AIDS epidemic in Florida this year. It will have spent $3,442,561 on the AZT program during the fiscal year ending September 30, 1988. AZT costs about $8,000 per patient; thus the program allotment will cover about 10% of the total AZT that would be needed by Florida's 4,424 patients reported to date.

AIDS and the insurance industry ● The AIDS epidemic adversely influences the insurance industry from two directions: it increases the costs of direct medical care for medical insurance and HMO companies and distorts the actuarial expectations of longevity. Currently many carriers are experiencing difficulty calculating the current and future costs of AIDS to their companies. Underreporting of the diagnosis of AIDS to insurance carriers is frequent; some doctors do this to protect the confidentiality of patients. Also, the criteria for diagnosis of AIDS has recently been revised and published by the CDC; many patients with earlier cases escaped detection and went unreported. In the early stages of HIV-1 infection, the diagnosis of AIDS may not be expected; patients will be treated but labeled with some other disease entity. In a survey conducted by the Census of the Certified Benefits Specialist, 50% of AIDS cases occurred in clients who were not identified as AIDS-related deaths until after the individual's demise.

In 1986 health insurers paid $200 million toward AIDS claims which represented 1% of the total $19.6 billion paid out that year. The average claim was $36,159. It was found that only 17% of AIDS patients had private health insurance. The relatively high cost of care per patient with AIDS, vis-a-vis, the much lower cost of care for the average individual in the 20-49 year old age group in which AIDS predominates, presents a legitimate and serious threat to certain small companies — particularly smaller HMOs and PPOs. The results of a survey conducted among 216 health plans indicate that over 39% are mapping strategies to deal with AIDS patients; 81% currently cover AIDS as a diagnosis; 9% exclude AIDS coverage, and 69% have instituted some type of case management. Managed care studies, fostered by the San Francisco General Hospital and by many insurance companies, have demonstrated that substantial savings can be realized by excluding most AIDS treatment from the hospital setting.

The life insurance industry is similarly threatened by AIDS. It has been reported that in 1986 $20 billion worth of individual life policies and an additional $15 billion of group life policies had been written in the United States on HIV infected persons. An

article in "Best Review" claims that 1% of the death claims in the U.S.A. are attributable to AIDS patients; this small percentage, however, could precipitate the bankruptcy of 10% of the life insurance companies in the United States. Superficially, this might not appear to be of major concern; but it could severely affect the savings of a significant percentage of the American population who depends upon the financial integrity of these insurance companies for their economic future.

The industry has responded to the AIDS crisis by requiring HIV antibody testing prior to issuing insurance to individual patients. The gay community, and others, have attacked this policy on the grounds that discovery and announcement of HIV infection would be a breach of individual confidentiality. Many state legislatures are debating whether the insurers have the right to test applicants for HIV infection. The District of Columbia and Maine have passed laws that prohibit HIV testing as a requirement for insurance. The fundamental question, as seen by the insurance companies, is "do they have the right to protect their financial stability; in fact, is it not their responsibility to determine who they can insure." No ready answers exist. Certainly the industry has been able to increase premium charges to individuals who practice other types of destructive lifestyles such as those who smoke or who are alcoholic. Insurance company executives argue that they should be allowed to proceed similarly with people infected with the HIV-1 virus.

Cost of AIDS to society: A perspective ● An estimated 4,700 people will be alive with AIDS in Florida at some time during 1988 and increase to over 22,000 by 1991. These numbers might be compared to individuals who died from other causes in Florida during 1986: heart disease 45,081; cancer 29,317; stroke 8,736; accidents 5,131; chronic obstructive lung disease 4,901; pneumonia and influenza 2,896; diabetes 2,002; suicide 1,959; chronic liver disease and cirrhosis 1,720; and homicide 1,745. Thus, by 1991, AIDS will follow only heart disease and cancer as a leading cause of death in Florida, assuming that there is no sudden increment in the numbers of people dying from these other diseases.[7]

Bloom and Carliner maintain that the lifetime cost of direct medical care for an AIDS patient should not exceed $80,000 between now and 1991. The cost for treatment of a heart attack in a male aged 35-44 is $67,000 (in 1986 dollars); $47,500 for cancer of the digestive system; and $28,600 for leukemia. Lifetime costs for care, regardless of age, is $68,700 for paraplegia resulting from a motor vehicle accident. Although the costs of treating an AIDS patient is high, it is similar to the expense of treating other individuals with lethal conditions.

In 1991 the direct costs of treating AIDS, both the personal medical care costs and the costs of education, research and blood banking, will total $66 billion. Alcoholism and alcohol-related illnesses cost $117 billion in 1986. In 1986 $33.7 billion was spent on tobacco-related products. Thus, AIDS is a very expensive illness but it fits into the range of expense for other destructive lifestyles.[8]

AIDS: The future ● The prospect for either eradicating the threat of AIDS through a vaccine or a cure during the next five years is extraordinarily remote. If a conceptual breakthrough in the scientific approach to treatment were to occur in the next year, it would take at least three years to conduct the necessary testing to assure the safety and long-term effectiveness of any therapy. Thus the immediate approach to curtailment of AIDS must be through education. This approach is not ideal but it may be having an effect. In this presentation we have listed projections of the numbers of cases of AIDS between now and 1991 based on trend lines that have existed for the last three years. However, if one looks at the rate of increase in the number of reported AIDS cases in the past year one can be quite sanguine that education may be working. The logarithmic increase in new cases has been slowed. The doubling time for new cases was 15 months for the three year period ending in 1987; for the past year the doubling time of new cases, for the nation as a whole, has slowed to over 24 months. If this trend continues then the future projections of AIDS costs reported here will be considerably overestimated.

References

1. AIDS Weekly Surveillance Report — United States AIDS Program, Center for Infectious Diseases, Centers for Disease Control, May 2, 1988.
2. Hardy, A.W.; Rauch, K.; Echenberg, D., et al. Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States, JAMA 255:209-215, 1986.
3. Scitovsky, A.A.; Cline, M., and Lee, P.R.: Medical Care Costs of Patients with AIDS in San Francisco, JAMA 256:3103-3106, 1986.
4. Scitovsky, A.A. and Rice, D.P.: AIDS: Cost in Dollars, Internist, April 1987, pp. 9-15.
5. Scitovsky, A.A. and Rice, D.P.: Cost of AIDS Care, Pub. Health Rep. 102:5-17, 1987.
6. Bloom, D. and Carliner, G.: Economic Impact of AIDS in the United States, Science 239:604-609, 1988.
7. Acquired Immune Deficiency Syndrome (AIDS) Surveillance Report, Department of Health and Rehabilitative Services (Florida), AIDS Program, Number 45 05/05/88.
8. Morgan, W.M. and Curran, J.W.: Acquired Immunodeficiency Syndrome: Current and Future Trends, Pub. Health Rep. 191:459-465, 1986.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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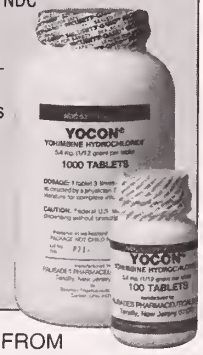

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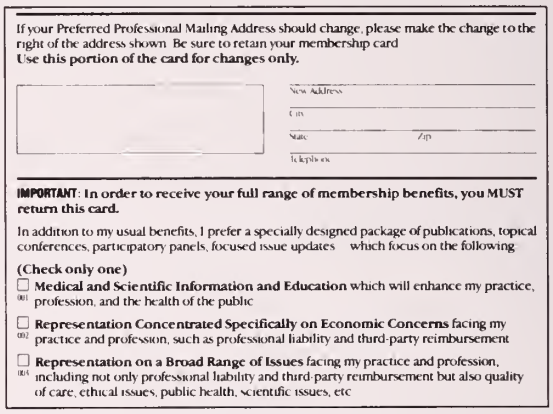

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James H. Sammons, MD
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The Florida Vascular Society

Prior to the annual meeting of the Society for Vascular Surgery and the International Society for Cardiovascular Surgery in Chicago on June 12, a group of 13 vascular surgeons from Florida founded a new state specialty organization, the Florida Vascular Society. This action was prompted by the fact that vascular surgery is a recognized specialty with approved fellowship training, board certification (approximately 800 board certified vascular surgeons as of June, 1988) and a steadily growing number of surgeons devoting the major part of their practice to the specialty. The new officers are Daniel B. Nunn, M.D., of Jacksonville, president; Stuart Farber, M.D., of Hollywood, president-elect, and William M. Blackshear, M.D., of Tampa, secretary-treasurer.

Charter members of the Society in addition to Drs. Nunn, Farber and Blackshear include Ian Reiss, M.D., and Anselmo Nunez, M.D., Miami, F. Joseph Dagher, M.D., and Larry Williams, M.D., St. Petersburg, James Seeger, M.D., Gainesville, Russell Samson, M.D., Sarasota, Raymond Alexander, M.D., Jacksonville, Paul Liebman, M.D., West Palm Beach, Floyd Bryan, M.D., Melbourne, and William Long, M.D., Tallahassee.

Vascular surgeons interested in membership should contact Dr. Blackshear at the University of South Florida Medical Center, College of Medicine, Medical Clinic, Box 33, Tampa 33612. The first meeting is scheduled in conjunction with the Florida Medical Association Annual Meeting in Hollywood on Saturday, September 10, from 9 a.m. to 12 noon.

Dr. Broadaway Reelected to AMA Board of Trustees

Rufus K. Broadaway, M.D., surgeon and senior vice president for Medical Affairs at Cedars Medical Center in Miami, has been reelected to the American Medical Association's Board of Trustees. He was first elected to the Board in 1982.

Since 1984, Dr. Broadaway has been an AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations and president of the American Medical Association Education and Research Foundation from 1983 to 1986.

Until his election to the Board, Dr. Broadaway represented the Florida Medical Association in the AMA House of Delegates as an alternate delegate from 1969 to 1971 and as a delegate from 1971 to 1982. His AMA activities have included service as chairman of the AMA Council on Long Range Planning and Development and as a member of the Special Committee of the House of Delegates that reviewed the Association's structure in 1975.

Dr. Broadaway has served as president of the Dade County Medical Association and as a Dade County delegate to the Florida Medical Association. He was a member of the FMA Board of Governors in 1978-79 and 1981-82 and was chairman of the Florida Medical Political Action Committee.

Born in Jackson, Miss., Dr. Broadaway received his M.D. degree from Harvard Medical School. He served an internship and residency at the Mary Imogene Bassett Hospital in Cooperstown, N.Y., and at Columbia Presbyterian Hospital, New York City. Dr. Broadaway is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. His academic appointments include clinical professor of surgery at the University of Miami School of Medicine. He has been chief of staff and chairman of the Department of Surgery of Cedars Medical Center.

Hospitals Ban Smoking

Among hospitals in Florida there is growing support for an idea whose time has come: ban smoking in hospitals.

Wade Edwards, vice president of the Florida Hospital Association, said the association has not conducted a survey among its members to determine how many have initiated restrictions or an outright ban on smoking, but hospital newsletters reveal "a great many" have restricted smoking to certain areas.

Some have eased into restrictions, then tightened to a complete ban of smoking inside the building.

"Over the past two years, the association has eliminated the smoking section at our meetings," said Edwards. "Among our 13 affiliated groups, with few exceptions, the participants do not smoke. At the seminars, there is virtually no smoking."

Asked the reason for the move, Edwards replied, "We thought it was the right thing to do — and we wanted to set an example."

Edwards noted Manatee Memorial Hospital in Bradenton, Baptist Hospital of Miami and Baptist Hospital in Pensacola have all banned smoking.

Ms. Ernestine Curry, program associate for the American Lung Association's Northeast Branch in Jacksonville, said three Jacksonville hospitals, Baptist

Medical Center, Memorial Hospital and the Mayo Clinic Jacksonville, have banned smoking.

Around the state, she said restrictions on smoking have been imposed by Memorial Hospital, Hollywood; Las Olas Hospital, Fort Lauderdale; St. Mary's Hospital, West Palm Beach; Venice Hospital, Venice; Hillsborough Hospital, Tampa; Fort Myers Community Hospital; Florida Hospital, Orlando; and Boca Raton Community Hospital. Undoubtedly, there are others of which the Lung Association has not been advised.

Florida Hospital in Orlando has had the policy of no smoking by the hospital staff for at least seven years, according to Tom Werner, hospital administrator. The hospital does permit patients to smoke in their own rooms, he said.

"It's something we're going to see more and more of," Werner said.

"Baptist Medical Center in Jacksonville instituted its smoking ban gradually," said Mrs. Diane Raines, director of the hospital's Southeast Heart Institute.

"We started out by designating areas for visitors and employees to smoke," she said. "Then, over a two-year period, we began limiting the number of areas while announcing that we were heading toward a no-smoking goal, meanwhile offering a smoking cessation program."

"January 1, 1988, was the target date. That's when we went non-smoking in the hospital except for a designated area for patients in the psychiatric section."

Mrs. Raines said initiation of the policy has stimulated mail response from many areas, with "the positive outweighing the negative."

"We've had a few employees, visitors and patients who've not been happy," said Mrs. Raines, adding that the Medical Center has had some trouble enforcing the ban. She estimated that the policy now seems to have become 95% effective.

The policy was proposed by a task force on smoking and health chaired by Dan Grigas, M.D., an internist and specialist in pulmonary diseases. Next, the task force presented the idea to the administration which, in turn, submitted it to the board, that was "very receptive."

Baptist Medical Center was the first existing Jacksonville hospital to initiate a no smoking policy, but Mayo Clinic, Jacksonville opened "smoke free" in October 1986.

Other Jacksonville hospitals are following the lead. St. Luke's is working toward initiation of such a program, as is St. Vincent's Medical Center. Riverside Hospital has announced there will be no smoking after January 1, 1989.

According to a study conducted by the Chicago-based American College of Healthcare Executives, nine out of ten American hospitals now are restricting smoking in their facilities. The study reported that of the 90% of respondents who reported having smoking restrictions in effect, 8% had bans on smoking by physicians, employees, patients and visitors.

USF Provides AIDS Education for Health Providers

The University of South Florida has been awarded a $183,000 contract with an anticipated three-year funding of close to $700,000, to provide AIDS education for primary health care practitioners.

"The funded project is designed to help physicians, dentists, nurses and other health care providers gain the up-to-date information they need to care for AIDS patients in their own practices. We view this project as an opportunity to make a significant contribution to the educational effort and to influence attitudes and behaviors among health care providers," said Michael Knox, Ph.D., associate professor and chairman of the Florida Mental Health Institute department of community mental health at USF.

Funding is provided through a subcontract with Emory University as part of its AIDS Training Network, which is funded by the Health Resources and Services Administration of the U.S. Public Health Service.

"We were impressed with what Dr. Knox and his staff have done to date and know that they are committed to this project," said Kathleen Miner, Ph.D., director of the Emory AIDS Training Network.

The department of community mental health has been involved in continuing education activities regarding AIDS since last year when it sponsored a one-day conference on AIDS: Mental Health Interventions. Since that time, the department has offered various workshops and hosted a monthly network meeting for health care professionals working with people affected by AIDS.

Dr. Knox said the contract requires that USF establish a "Center of Excellence" focusing on issues related to mental health and AIDS. The department will concentrate on providing continuing education for primary care providers in Florida,as well as develop a special expertise in AIDS as it relates to mental health and substance abuse services for the entire region served by the Emory AIDS Training Network.

According to Dr. Knox, "The educational program will rely heavily on departmental faculty, but will also draw on expertise nationwide including the national Centers for Disease Control in Atlanta (CDC), the National Institute of Mental Health, National Institutes of Health and other nationally recognized experts in AIDS.

"We also intend to involve faculty resources from the USF Colleges of Medicine, Public Health, Nursing and Social and Behavioral Sciences," he said.

Physicians as 'Double Agents'

In a recent column in *American Medical News*, Harry Schwartz pointed out that physicians were being forced more and more to become what amounts to "double agents" in patient care, with all that this implies. A double agent in the world of international intrigue agrees to work on behalf of two masters who have conflicting goals and purposes. Often, neither is aware of the agent's responsibility to the other. In addition, it is sometimes necessary for double agents to act on behalf of only themselves, for their own well-being or even survival. The role of a double agent has to be an uncomfortable one, especially for physicians. By definition a double agent can hardly be loyal to both masters and perhaps to neither of them, and, in any event, loyalty to oneself may sometimes become paramount.

Many physicians—and there are more each day — are finding themselves in this uncomfortable role. On the one hand, patients and the public expect them to work fully on behalf of those patients who seek their help, while at the same time they are being pressured more and more to serve as agents of government and others who are trying to reduce the amount and cost of services that are purchased by third parties for patients. This unwanted dual role is already causing serious discomfort for many physicians, who, caught in what seems like an ever-tightening vise, must also try to protect their own personal moral integrity and sometimes their own economic survival. If nothing is done, all this can only get worse as the demand for services inevitably increases in the face of an obviously growing need to curtail costs.

There are those who say that the supply of resources would be adequate to meet the demand for services if ineffective and unnecessary services were eliminated, and they call upon the medical profession to help bring this about. At best, however, and even if fully accomplished, this would do only for a while because the disparity between a virtually unlimited demand for services and clearly limited resources can only increase. In the meantime, many who are powerfully situated believe that the cost control measures that are being imposed, including putting physicians in the position of "gatekeeper," with responsibility to protect quality while controlling costs in patient care, will force physicians and the medical profession to do what no one really wants to do: be responsible for rationing care. Harry Schwartz put his finger right on it. Physicians are being placed in the role of "double agents" in health care. On the one hand, they want and are expected to be advocates for patients' interest, while on the other, they are finding themselves to be increasingly locked into being unhappy front-line agents for those whose goals are to achieve cost control.

It surely would not sit well with patients or the public if it became generally known that physicians were being maneuvered into becoming *de facto* double agents in patient care—and this very much against their will, their tradition, and their ethics, which have always put patients' interests first. As Schwartz suggests, perhaps it is time for physicians and organized medicine to begin to publicize to their patients and the public the fact that society itself is forcing physicians to become what amounts to double agents in patient care, and that this is not in the long-term interests of either patients or of soceity. If there is to be integrity and trust between doctor and patient, and this has always been a *sine qua non* in patient care, then a physician's first duty must be to a patient. Patients expect nothing less, and in the final analysis, society expects nothing less.

It would not only be a tragedy but a disaster for medicine if physicians and the medical profession were, by their own default, to become institutionalized as "double agents" in this nation's health care system. What is urgently needed now is for society, whether in the form of government, health insurance programs, or health care plans, to decide and make clear what they will pay for in health care and what they will not. This would free physicians to do what they should do and trained to do — what they think is best for their patients — and do this within the framework of whatever resources society decides it can afford. This will not be easy to do, but the stakes for patients and the public are very high indeed.

There may, however, be a precedent worth some thought and study. As Dr. Kitzhaber points out elsewhere in this issue, the state of Oregon has been one of the first to recognize and face this problem and has already begun to take some steps to deal with it. But there is as yet no widespread general awareness. The immediate need is for affirmative action by individual physicians with their patients and by the medical profession with society as a whole to publicize this issue and then to work with the payers of health care to find ways to separate the roles of church and state, so to speak, or in health care, the appropriate roles of physicians and society.

Malcom S.M. Watts, M.D.

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The Dangers Of a House Divided

We don't have to go back too far into history to uncover a classic example of why unity is important for the medical profession. Many of us remember clearly that in 1949 the British government was wrestling with the problem of selling the concept of the National Health Service to the country's medical establishment. The biggest hurdle was a split between consultants and general practitioners. The consultants, or specialists, worked only in hospitals, while the GPs worked the mean streets among the masses. Never in a million years would the specialists accept any pay system that put them on a par with the lowly GPs. Yet, as we all know, the National Health Service was established in Great Britain.

In a recent article in *American Medical News*, Dr. Harry Schwartz, a New York journalist who specializes in health care issues, described the divide-and-conquer tactics used by the Labour government to launch the British adventure in socialized medicine. The key, according to the government minister who put the deal together, was simple. To get the consultants to go along, he said, "I stuffed their mouths with gold." What he did was set up a system of merit bonuses for which only consultants could qualify. Now clearly segregated from the GPs, the consultants hopped happily aboard the National Health Service bandwagon. Today, more than 30 years later, they — and only they — get those merit bonuses.

Widening the Divisions

This historic example of disunity, and the exploitation of that disunity, continues to serve as a warning to American physicians. Or does it? Surely, this divide-and-conquer technique would never be used to bring about more government intrusion into America's health care system. Or would it? And if it were attempted, American physicians would never fall into the trap. Or would they?

Unfortunately, today there *are* divisions among physicians — divisions that are growing wider — divisions that can be exploited — divisions that *are* being exploited. Ironically, some of these divisions are based on the issue of fees paid to different types of physicians, the same issue that allowed Britain's doctors to be isolated and driven apart.

All of us should be concerned by this trend toward disunity, not just for the harm it does to our profession, but for the harm it portends for the quality of health care in this country *and* because unity of purpose continues to be our best hope of improving health care delivery in the United States.

A Common Vision

The American Medical Association has long maintained that physicians must share a common vision to succeed in advancing quality health care, as the recent battle over physician diagnosis-related group (DRGs) demonstrates. We — along with ASIM and others — reacted quickly when the Administration attempted to draw up a DRG program that would apply to hospital-based physicians. By working together we rallied a significant number of congressional votes in opposition to the government's proposal. More than one-half of the senators and over 300 representatives eventually went on record opposing hospital-based physician DRGs.

We won that battle thanks to cooperation by the AMA and state, county and medical specialty societies. But the fight is far from over. And we didn't come out unscathed. One result was a break in our ranks when congressional staffers began to deal separately with the specialty societies. This disunity was due partly to the trend for specialty societies to set up lobbying arms in Washington to concentrate on their own narrower interests, weakening what should have been a united effort to represent all the interests in medicine. It also reflects the fact that, like the British Labour government of 1949, Washington today is all too willing to drive wedges between one physician group and another, especially if we provide the wedges, and if we create the cracks where those wedges can be inserted.

The goal of the AMA is to see that physicians are not driven apart. We work closely with local, state and medical specialty societies to ensure that our efforts on behalf of physicians and patients are coordinated and effective. As a part of that, specialty and subspecialty organizations need to set aside petty turf disputes and personal agendas to work for the welfare of the entire profession and the public. We did that with physician DRGs, and we also did it with the AMA/Specialty Society Medical Liability Project.

Our Last Chance?

Working together on these and other issues, we have demonstrated that physicians can cooperate with

each other in surmounting formidable obstacles. No doubt the future will challenge us even more. The Harvard relative value study (RVS) is sure to be greeted with mixed emotions. Yet, if we fail to stand together to give the RVS concept a chance to succeed, we may be squandering our last chance to create, by ourselves, a workable solution to the issue of physician compensation. Heaven knows, there are plenty of others who would like to put forth their own solutions.

For more than 140 years, the AMA has been a vital voice for America's physicians — speaking out, standing fast, sponsoring *appropriate* change, shaping the future of medicine. And medical specialty societies have been valuable partners in this effort. We must protect that partnership, because the evidence is clear: If we can't maintain unity in the house of medicine, nobody is going to step in to do it for us.

James E. Davis, M.D.

Dr. Davis is president-elect of the American Medical Association.

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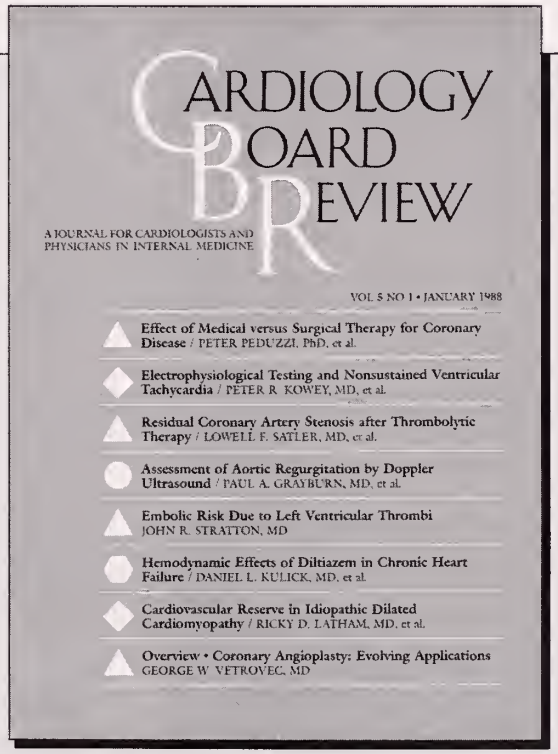

*Journals reviewed include: *Circulation*, *American Heart Journal*, *Journal of the American College of Cardiology*, *British Heart Journal*, *Chest*, *The American Journal of Cardiology*, *The New England Journal of Medicine*, *Annals of Internal Medicine*, *American Journal of Medicine*, and *The Journal of the American Medical Association*.

Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

Super Tuesday Highlights

On March 8th, Florida Medical Auxilians joined the Florida Medical Association in a statewide drive to collect as many petition signatures as possible. These signatures are being collected in order to place our constitutional amendment on the ballot in November. This amendment limits noneconomic damages in civil cases to $100,000 per case, and is felt by the Florida Medical Association to be an important step in helping to resolve the insurance crisis that we are presently experiencing in our state.

The majority of auxiliaries in the State of Florida participated, and most were outstanding in their endeavors. Lee County Auxilians collected 19,267 petitions. Their highly organized team was made up of physicians, auxilians, office staff, and other citizens, and was headed by chairperson Karen Tienstra with assistance from Debbie Bloy and Linda Chazal. The support of area hospitals was also helpful in making their effort a success. The organization appointed area captains from the auxiliary. This plan had been formulated and discussed at a joint medical staff/auxiliary meeting in February. A workshop was held prior to Super Tuesday to educate volunteers. "There was an extremely positive response from the physicians, and many volunteered to work shifts and also volunteered their office staff to help," said auxilian Linda Chazal.

Sarasota County was also very active on Super Tuesday. The project was introduced by a representative of the FMA and it was decided that the medical auxiliary and the medical association would share the responsibility for the project. Charlotte Ellis, an active auxilian in Sarasota County, said, "Physicians scheduled workers which consisted of doctors, office staff, auxilians and other family members. This was followed by an education workshop with the FMA representative. The medical society office served as headquarters for the project." Work was mixed with pleasure when a dinner meeting for the medical staff and the medical auxiliary followed the long day of petition collecting.

In Duval County, greater than 9,000 petitions were collected. Auxilians organized the precincts, which were staffed by themselves and volunteer physicians. According to Esther Foley, Duval County Medical Auxiliary President, physicians quickly became convinced that patients were the best resource available for obtaining petitions. An ongoing project has been set up consisting of teams and team captains to continue the signature collection. These team captains who are volunteer physicians contact members regarding participation. Each pledged to collect 200 signatures by May 31st. "This plan has proved effective in Duval County and we are close to obtaining our required number of petitions," said Mrs. Foley.

As the auxiliary representative to Marion County, Charlotte Wright was in charge of organizing the petition effort. "We called upon every member of the medical society and auxiliary to devote a portion of Super Tuesday to the poll activities. The response was very good with greater than 70% of the medical society working," said Mrs. Wright. Several retired physicians worked up to 12 hours on Super Tuesday. The medical society office served as the operations base for Super Tuesday.

With efforts like the above four counties common throughout the State of Florida, the signature response was greater than had been expected. To date, 278,502 signatures have been collected. By July 5th, a total of 342,939 are required in order to place the constitutional amendment on the ballot in November.

Auxilians throughout the state felt surprisingly strong public support in this vital issue. In view of these gains, we must continue with the drive to complete the necessary goal by July 5th. Many physicians throughout the state have volunteered to use their offices and office patients in an effort to obtain these signatures. Additionally, FMA members have continued the effort in order to increase the number of signatures.

Auxilians throughout the state extend a heartfelt "thank you" to the members of the FMA for their assistance in coordinating this project.

Mrs. Thomas J. (Jill) Bixler
Tallahassee

BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

The Man Behind the Syndrome

by Peter Beightan and Greta Beightan, 232 pages, Springer-Verlag, Berlin, Heidelberg, New York, Tokyo, 1986.

What kind of people are honored by the eponyms of medicine's best known inherited syndromes? Have you ever wondered who they were or how they came to be so honored? If so, then Peter and Greta Beighton have written just the book for you.

It is not surprising that each has his own story, but the contrasts between them are fascinating. For instance, Guillaume Duchenne (Duchenne's dystrophy) had "an undistinguished academic career and failed to get an academic appointment." As he pursued his studies by following his patients through the hospitals of Paris he was "mocked by interns and rebuffed by senior medical staff." In contrast, Guillaume Dupuytren (Dupuytren's contracture) was so famous a surgeon that he became a baron and a millionaire. He disliked writing himself so most of his brilliant ideas were recorded for him by a train of loyal followers.

The careers of some great men seem to have happened almost like an accident. Phillippe Gaucher (Gaucher's disease) entered medical school only after he failed the entrance examination for natural sciences. Henri Rendu (Rendu-Osler-Weber syndrome) went first to a school of agronomy, then got a doctorate in geology before finally entering the study of medicine.

There are the sophisticated and cosmopolitan — like James Paget (Paget's disease of bone, Paget's disease of breast, etc.) who included among his circle of friends Gladstone, Browning, Huxley, Darwin, and Florence Nightingale. And then there are such men as George Huntington (Huntington's chorea) who delivered his classic paper the year after he finished medical school and then spent the rest of his life as an obscure small town family practitioner — much loved by his patients and family but otherwise unknown.

Some were the victims of tragedy. Ludwig Pick (Niemann-Pick disease) died in a Nazi concentration camp after having served the German army with distinction in World War I. Gilles de la Tourette (Gilles de la Tourette's syndrome) was shot in the head by a paranoid patient at the age of 41. This resulted in development of a manic-depressive disorder that led to his having to be placed in a mental hospital six years later where he died at age 49.

Some were heroic. Johannes Pompe (Pompe's disease) was arrested and executed by the Germans for blowing up a strategic railway line shortly before his native Holland was liberated. Max Wilms (Wilms' tumor) died of diphtheria which he caught from a prisoner of war on whom he was operating. The prisoner lived.

Some of the great men were known for their hard-headedness. When Harald Hirschsprung (Hirschsprung's disease) became director of the Queen Louisa Hospital for Children in Denmark, he insisted on putting animal pictures in the rooms instead of bible verses ordered by Queen Louisa. As a result, she refused to ever set foot in the place again. Others were known for their charity. Johannes Peutz (Peutz-Jeghers syndrome) was active in programs for orphans and the aged in his community despite holding prominent medical posts.

These and many other such insights are the subject of this fascinating encyclopedia of the men behind the syndrome. Those who enjoy such tidbits will appreciate the extensive work done by the authors to compile this listing of 200 famous eponyms.

Henry L. Harrell Jr., M.D.
Ocala

Dr. Harrell is associate editor of the Journal and is in the practice of internal medicine in Ocala.

Overcoming Breast Cancer

by Genell Subak-Sharpe, 1st edition, 181 pages, price: $16.95. Doubleday & Co., Inc., Garden City, N.Y.

This book is written by a former New York *Times* correspondent who has written or edited more than a dozen books on health and medicine. It also lists some very impressive consulting and contributing editors, all of whom are physicians. This publication is a part of the Frontiers of Medicine series marketed by Doubleday & Company.

It is a very well written, well thought-out, concise publication for non-healthcare personnel con-

cerned about breast cancer. This book addresses such important topics as detection and diagnosis, the importance of regular breast examinations and the types of breast cancer a woman may encounter. There are excellent chapters concerning the treatment of this disease along with very supportive and concerned dialogue reflecting the author's attempt to have the patient understand such areas as breast reconstruction and the strength necessary to make a comeback with family and friends after having breast cancer.

All manner of breast cancer therapy, including surgical, radiation and chemotherapy, along with hormonal considerations are discussed in a way that is easily understood by the nonmedical person. A chapter on nutrition is most explicit in helping the patient comprehend the current order of knowledge as it relates to fact versus myth in breast disease. There is a very good chapter cautioning the patient who may seek experimental or nonproven methods of treatment for her breast cancer. The reader is constantly reinforced in the important decision making process of seeking treatment only from qualified and licensed healthcare professionals.

This book includes an excellent appendix with a directory of resources for patient assistance and guidance. Such organizations as the American Cancer Society, the American College of Surgeons and the American Society of Plastic and Reconstructive Surgeons are listed. There is even a section recommending home health care services and other books and publications on the subject of breast cancer.

The glossary is complete and assists the reader in understanding the medical terms used in the test. This book makes no value judgments about breast cancer therapy, but attempts to provide valuable information for the breast cancer patient.

Pierre J. Bouis Jr., M.D.
Tampa

Dr. Bouis is a contributing editor of the Journal and practices obstetrics-gynecology in Tampa.

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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

AUGUST

Otolaryngology for the Practicing Pediatrician, August 4-7, Mariner's Inn, Hilton Head Island, South Carolina. Contact: Debbie Shealy (803) 798-6207.

SantaFe HealthCare Physicians' Retreat, August 5-7, Palm Coast Sheraton, Palm Coast. Contact: Cathy Allison (904) 388-2188.

ACLS Provider Course, August 6-7, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

Fundamental & Clinical Aspects of Internal Medicine, August 7-20, Sheraton Bal Harbour, Bal Harbour. Contact: Jose S. Bocles, M.D. (305) 547-6063.

Arrhythmias: Interpretation, Diagnosis and Management, August 19-20, Grand Cypress Hyatt, Orlando. Contact: Deborah Wilderson (800) 421-3756.

Risk Mamagement Seminar, August 20, Holiday Inn, Coral Gables. Contact: M.P. Demos, M.D. (800) 431-3878.

An Update on the Management and Treatment of a Diabetic Patient, August 25, Fawcett Mem. Hosp., Port Charlotte. Contact: Linda Taylor (813) 627-6139.

Wound Dehiscience in the Trauma Patient, August 25, Ind. Riv. Mem. Hosp., Vero Beach. Contact: Erol Atamer, M.D. (407) 567-2005.

Risk Management Seminar, August 27, Bay County Medical Soc., Bay County. Contact: Bay County Medical Soc. (904) 769-1511.

SEPTEMBER

Clinical Update: Acid-Peptic Disease, Sept. 1, Delray Comm. Hosp., Delray Beach. Contact: Ruth Stewart (407) 495-3248.

19th Annual Pediatric Labor Day Symposium, Sept. 2-4, Pensacola. Contact: Garth Grove, M.D. (904) 474-7101.

Risk Management Seminar, Sept. 8, Broward Co. Medical Soc., Hollywood. Contact: Broward Co. Medical Society (305) 525-1595.

2nd Annual Clinical Update on Health-Behavior & Disease, Sept. 10, Hyatt Regency, Tampa. Contact: Ravji Bhatty, M.D. (813) 237-3914.

Risk Management Seminar, Sept. 14, Charolotte Co. Medical Society, Charlotte County. Contact: Charolotte Co. Medical Society (813) 625-6229.

Magnetic Resonance Imaging A Technologists New World, Sept. 15-17, Holiday Inn, Lake Buena Vista. Contact: Martin Silbiger, M.D. (813) 974-2538.

Pediatrics for the Practitioner — Update on Infectious Diseases, Sept. 16, Sheraton Tampa East, Tampa. Contact: Herbert H. Pemerance, M.D. (813) 974-2538.

Current Concepts in the Diagnosis & Treatment of Adult Heart Disease, Sept. 16-17, New World Landing, Pensacola. Contact: Phyllis Connerley (904) 478-4460.

Fall Physician Cardiology Symposium, Sept. 17, Watson Clinic, Lakeland, Richard Mackesy (813) 680-7636.

ACLS Instructor Course, Sept. 17-18, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

Basic Cardiac Life Support for Physicians, Sept. 19, University Comm. Hosp., Tampa. Contact: Jim Connolly (813) 972-7270.

The 14th Annual Gulf Coast Internal Medicine Conf., Sept. 23-24, New World Landing, Pensacola. Contact: Dolly Partridge (904) 434-4818.

Tutorial Courses of Instruction In Acute Cardiac Care, Sept. 26-Oct. 1, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Rehabilitation of the Post-MI Patient, Sept. 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

Endoscopic Sinus Surgery: Medical and Surgical Considerations, Sept. 29, Ind. Riv. Mem. Hosp., Vero Beach. Contact: Erol Atamer, M.D. (407) 567-2005.

The Journal of the Florida Medical Association, Inc.

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Please print or type all information requested and return this form to Kathy S. Lundy, Managing Editor, *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203. **Deadlines for publication are the first of the month preceeding the month of publication.** *For example:* An ad to be run in October should be received by *The Journal* by September 1. **Classified advertising costs:** $10.00 for 25 words or less; then 25¢ for each word thereafter.

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EMERGENCY PHYSICIANS: Excellent opportunities available for full-time and part-time physicians on the East Coast, West Coast and Panhandle portions of the state. Hospital volumes vary. Positions offer excellent compensation and malpractice insurance. Respond with C.V. to Anita Stirt EMSA, 100 N.W. 70th Avenue, Plantation, FL 33317, or call 1-800-443-3672.

GENERAL INTERNIST, RHEUMATOLOGIST, NON-INVASIVE CARDIOLOGIST, PEDIATRIC SURGEON, OBSTETRICS & GYNECOLOGY, GENERAL AND VASCULAR SURGEON, INFECTOUS DISEASES, OTOLARYNGOLOGIST, AND PEDIATRICIAN: 40 physician multi-specialty group in W. Palm Beach, FL seeks dynamic, confident physicians for private practice in fully equipped, new, suburban branch offices. Candidates must be personable and well qualified; emphasis on high quality care. Financial package based on incentive with full partnership in 3 years. Send CV to Joseph V. D'Angelo, M.D., Recruiting Chairman, Palm Beach Medical Group, Inc., 705 N. Olive Ave., W. Palm Beach, FL 33401.

LOOKING FOR A PARTNER! Tired of E.D. hassles, hospital politics, night shifts, abusive patients? Come to Lakeland, Florida. Join me in Emergency Medical Services Urgent Care/ Industrial Medicine. Remuneration package initially $100,000 + malpractice. Greg White, M.D., F.A.C.E.P., Quality Care North, 5040 U.S. Highway 98 North, Lakeland, Florida (813) 859-3511. Send C.V. and/or call and ask for Cheryl.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking full and part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

FAMILY PRACTICE — Great opportunity to join a busy solo practitioner in Lake Worth (West Palm Beach). Board certification/eligibility required. Contact Art Altbuch, M.D., 3918 Via Poinciana, Suite 5, Lake Worth, FL 33467, 305-433-1700.

INTERNIST, FAMILY MEDICINE, OB/GYN: Practice in South Florida with one of the Nation's largest investor owned HMO's. We offer a competitive salary, exceptional benefits plus you will enjoy paid malpractice insurance coverage. For confidential consideration, send your C.V. to Physician Recruitment CIGNA Healthplan of South Florida, 6301 NW 5 Way, Suite 4100, Ft. Lauderdale, Florida 33309.

FP, GP, IM needed for salaried positions in Alabama. Also, guarantees if you prefer to establish your own practice. Compensation packages (including malpractice) more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

INTERNIST WORKS 3 days per week. Will share office for ½ (half) overhead, about $650. (813) 262-3699.

FAMILY PHYSICIAN: Ethical ambitious team player to join an expanding multi-office group. Offering excellent compensation-package including reimbursed malpractice insurance. Beautiful Tampa Bay area, Family Medical Group, 2114 1st St. W., Bradenton, FL 34208, (813) 749-1228.

FAMILY MEDICINE: Busy BC F.P. group in W. N. Carolina needs BE/BC assoc. Compet. grtee. plus productivity/fringe benefits. Buy-in provision. Paradise! Picturesque community w/cultural & recreational amenities. 1 hr. fr. Asheville; 90 mins. fr. Charlotte. Contact Don Gustavson, TYLER & CO., 9040 Roswell Rd., Atl., GA 30350. Call (404) 641-6411.

MEDICAL DIRECTOR

The Broward County Public Health Unit seeks a progressive, compassionate BE/BC internist with strong clinical skills to provide leadership to a dedicated staff on an AIDS Outpatient Treatment Facility in beautiful South Florida. Candidate must have or be eligible for Florida licensure. Opportunity is available for a clinical appointment to a major university as well as clinical research.

Competitive salary and excellent benefits package available. Send CV and 3 letters of recommendation to:

Van J. Stitt Jr., M.D., MHA
Medical Executive Director
Broward County Public Health Unit
2421 Southwest 6th Avenue
Fort Lauderdale, FL 33315

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DIRECTOR POSITIONS AVAILABLE for primary care physicians with ER experience. Openings in Tampa area, West Palm Beach, Jacksonville area. Staff positions available for physicians with ER experience in Tampa, Palm Beach, Gainesville, Sebring. BC/BE in EM to staff busy ER in Winterhaven. Excellent compensation. Send CV to Coastal Emergency Services of Orlando, Inc., 475 Montgomery Place, Dept. SJY, Suite 100, Altamonte Springs, FL 32714 or call 1 (800) 877-2232 ext. 832.

FAMILY PRACTICE. Marshfield Clinic is seeking BE/BC Family Practitioners to join its expanding department in Marshfield. The department is currently staffed by five Family Practitioners with plans to ad three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available inhouse. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. Salary and fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715) 387-5376.

DERMATOLOGIST, BC/E — California — Opportunity to establish financially and professionally rewarding private practice with no investment, guaranteed income. Low malpractice rates. Growing area, service area population now 90,000. Proven potential. In Central California's San Joaquin Valley, Tulare offers family environment, abundant outdoor recreation, beautiful homes attractively priced, good schools, restaurants, shopping, many community activities. Easy access to all California attractions. Please send CV to Tulare District Hospital Physician Recruiting Office, P.O. Box 90112, Los Angeles, CA 90009 or call (213) 216-2687.

OCCUPATIONAL MEDICINE: Physician relocation specialist. Nineteen years experience nationwide. Send Curriculum Vitae in confidence. Robbins Med-Tech, P.O. Box 51509, Jacksonville, FL 32240. 904-223-0440.

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INTERNIST/FAMILY PRACTITIONER NEEDED Excellent opportunity for physician to join an established practice. The Palma Ceia Clinic is located in South Tampa and has been in operation since 1948. We are looking for a hard working physician and will offer a substantial base plus productivity. Send resume to: Anita E. Ramirez, Administrator, 3012 Estrella, Tampa, FL 33629.

PHYSICIAN: S. Florida HMO seeking a qualified, competent, confident and CARING hands-on Family Medicine or Internist Physician. Board Certified/Eligible preferred. Resume to: Jove Med-Care, 5200 NW 33 Ave., Ft. Lauderdale, FL 33309, Attn: S. Steinberg.

ALL SPECIALTIES REQUIRED: Physician relocation specialist. Sunbelt locations with groups or hospital based. Send Curriculum Vitae in confidence. Robbins Med-Tech, P.O. Box 51509, Jacksonville, FL 32240. 904-223-0440.

PART TIME INCOME OPPORTUNITY Expanding national health group seeking part time physician for occupational medicine practice. Potential for full time position to evolve. Involves treatment of work related injuries and physical exams. Must have liability coverage. Call K. F. Richmond at (904) 354-4531.

GENERAL INTERNIST FOR busy group practice. Tampa Bay Area. Salary guarantee with incentives and full benefits. Call (813) 654-2273.

EMERGENCY MEDICINE opportunity in beautiful W.N. Carolina. Competition salary plus benefits. Paradise! Picturesque community w/cultural and recreational amenities. BE/BP in EM, FP, IM preferred. Contact Don Gustavson, Tyler & Co., 9040 Roswell Rd., Atlanta, GA 30350. Call 1 (800) 223-3659.

TAMPA BAY AREA — Neurology, O/S, EM, IM, Occ. Med. Send CV to M.C.A., P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

ORLANDO AREA (around lakes) — FP, IM, O/S, Non-Inv Card, Ped, Neur, Pulmonary. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

PANHANDLE — OB/GYN, FP, ENT, Ped, O/S, An. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

N.E., FLORIDA — FP, O/S Non-Inv Card, ENT, AN, Rhu, OB/GYN. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

FLORIDA: WANT A CHANGE OF PACE? AMG/ Board Certified Anesthesiologist. Minimum five years post certification, preferably ten, managerial experience. Join four anesthesiologists (two boarded), one hospital CRNA. Progressive community hospital on Fla. West Coast. Fee for service, no O.B., infants, or OHS, limited trauma, rare post mid-night emergencies. Sixty cases (35% M.C.) a month per M.D. Large outpatient practice, forty working days per year for CME and vacation. Must have Florida license, opening May 1st. Discuss with us your abilities, strengths. Send full CV/passport photo to: Florida Medical Association, Inc., P.O. Box 2411, C-1469, Jacksonville, FL 32203.

RADIATION ONCOLOGIST: Board Certified or Board eligible to work under the supervision of medical director at Hernando Cancer Center, Brooksville, FL. Salary: $50,000 annually. Send curriculum vitae to: V.R. Emandi, M.D., 14535 Cortez Blvd., Brooksville, FL 34613.

RADIOLOGIST NEEDED to join expanding group in central Florida Lake Country. Send CV to Raymond E. Lovelace, M.D., P.O. Box 3477, Sebring, FL 33870. (813) 385-4348.

S.E. FLORIDA — OCC. MED. (must have FAA certification), FP (female), O/S (hand). Send CV or telephone. Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, (813) 968-3878.

GEORGIA: METROPOLITAN ATLANTA area, 15 miles from the city. Primary care physician with ER experience. 13,000 patient visits per year, expanding ER in a new hospital. Excellent compensation. Northeast Atlanta — 11,000 patient visits per year. Primary care physician with ER experience — outstanding compensation package. Send CV to Coastal Emergency Services of Orlando, Inc., 475 Montgomery Place, Dept. SJY, Suite 100, Altamonte Springs, FL 32714 or call 1 (800) 877-2232, ext. 832.

FAMILY PRACTICE: Winter Park Memorial Hospital, a 301-bed, not-for-profit hospital located adjacent to Orlando, seeks two (2) Board certified or Board eligible Family Practice physicians to become associates of two (2) well established, growing Family Physician practices. Contact Director of Medical Staff Services (407) 646-7495.

OPPORTUNITIES FOR FAMILY PRACTICE/GENERAL Internist, Board Certified or Board Eligible, to join an expanding Family Practice Group in one of the fastest growing counties in Florida. Send resumes to: Mr. Martin E. Dolence, Jr., CPA, 6314 Corporate Court, Suite C, Fort Myers, FL 33919, or call (813) 489-2227.

INTERNIST/RHEUMATOLOGIST seeks practitioner in any specialty to share large equipped office in Miami area. Available immediately call (305) 856-6161.

PHYSICIAN-FL lic'd for fast growing walk-in clinic in east central FL. Full time. Competitive salary in a pleasant town near beaches. Send CV to P.O. Box 16003, Tampa, FL 33687 or call (813) 989-1468.

ORTHOPAEDIC SURGEON — Position available in an established practice in Ocala, Florida for a BE/BC Orthopaedist. Possibility of an association or partnership depending on interest and suitability. (904) 629-7011.

GENERAL THORACIC & VASCULAR SURGEON as associate or share office space in Orlando area. Florida license and Thoracic Boards. C.V., photo and personal information with references first letter please. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1366, Jacksonville, FL 32203.

GYNECOLOGY: Excellent opportunity for a gynecologist to establish a new private practice in a rapidly growing suburban area of Southwest Florida. Hospital currently does not offer obstetrical services but is considering addition of obstetrical services in the next five years. Office space is available adjacent to the hospital. If you are interested in this opportunity, contact Tracy Chelf, East Pointe Hospital, 1500 Lee Boulevard, Lehigh Acres, Florida 33936, 1 (800) 226-2101.

GENERAL SURGEON/ THORACIC SURGEON: A rapidly growing suburban area in Southwest Florida seeks general surgeon/thoracic physician to start a new private practice. Excellent surgical facilities available. Office space is available adjacent to the hospital. If you are interested in this opportunity, contact Tracy Chelf, East Pointe Hospital, 1500 Lee Boulevard, Lehigh Acres, FL 33936, 1 (800) 226-2101.

FAMILY PRACTICE: Suburban, Southwest Florida local seeks an additional family practice physician to start a new private practice. Dynamic growth in area, particularly in the young family population segment. Office space available adjacent to hospital. If interested in this opportunity, call Tracy Chelf, East Pointe Hospital, 1500 Lee Boulevard, Lehigh Acres, FL 33936, 1 (800) 226-2101.

SEVERAL OUSTANDING CALIFORNIA practice opportunities in OB/GYN, Urology, G.I., Cardiology, Pulmonary Diseases, General Internal Medicine and F.P. As retained consultants to quality Hospitals, HMO's and Group Practices in Northern and Southern California, we can discuss each practice in detail. Please call or send a c.v. for additional information. Confidentiality is assured. Robert Grant Associates, Inc., "Physician Advocates" 50 California Street, Suite 400, San Francisco, CA 94111, Ken Baker at (415) 981-7424, collect.

CENTRAL AND COASTAL FLORIDA/NATIONWIDE opportunities available now for BC/BE physicians. Complete confidentiality, send CV or telephone: Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, (813) 968-3878.

Family Practitioners & Pediatricians

Brownsburg Medical Clinic

Brownsburg Medical Clinic is a well-established, 3-physician family practice affiliated with Methodist Hospital of Indiana, a renowned research, teaching and tertiary care hospital. We'll soon be located within a new professional center in an attractive, growing, "bedroom" community near Indianapolis.

If you are a board certified or eligible Family Practitioner or Pediatrician, we invite you to join our group practice. You'll enjoy a generous incentive plan with excellent salary and benefits. Our practice is predominantly fee for service, and relatively free of the onerous constraints found in many cities.

For more information on these opportunities and the Indianapolis area, please contact **James Black, MD, at 317/852-2251,** or write:

James Black, MD, Brownsburg Medical Clinic, Brownsburg, IN 46112. Equal Opportunity Employer.

ONCOLOGIST, BC/E — California — Opportunity to establish financially and professionally rewarding private practice with no investment, guaranteed income. Low malpractice rates. Some general Internal Medicine necessary initially. Growing area, service area population now 90,000. In Central California's San Joaquin Valley, Tulare offers family environment, abundant outdoor recreation, beautiful homes attractively priced, good schools, restaurants, shopping, many community activities. Easy access to all California attractions. Please send CV to Tulare District Hospital Physician Recruiting Office, P.O. Box 90112, Los Angeles, CA 90009 or call (213) 216-2687.

OB/GYN - City on Tennessee state line near Pickwick Lake needs additional OB/GYN to work with two OB/GYNs on staff. Beautiful town near large recreational areas, excellent schools, strong diversified industrial ecomony, temperate climate. Good malpractice insurance situation: generous guarantee and other assistance. Contact Robert Barrett, Magnolia Hospital, Alcorn Drive, Corinth, MS 38834. Phone 601-286-6961, Ext. 107.

FAMILY Practice (BC/BE), or Neurologist, or Pulmonary Specialist, Central Florida, outdoor recreation and resort area, well-equipped, modern hospital, positive demographics, congenial medical staff, small-town atmosphere, yet near major urban area. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1464, Jacksonville, FL 32203.

BC/BE FAMILY PRACTITIONER to join six physician department in a 38 member multispecialty group located on eastern Florida's treasure coast. Excellent salary, benefits and growth potential within this progressive organization. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1441, Jacksonville, FL 32203.

EMERGENCY PHYSICIAN: Small group urgently seeks emergency physician on Florida's West Coast. Total remuneration approximately 140k. EM or Allied Board preferred. Call (813) 475-2250.

FAMILY D.O./M.D. Opportunity to take over small practice with no investment or overhead. Staff and facility provided. Ask for Dr. Reis, Chirocare, Orlando, FL (305) 239-0202.

FLORIDA — EXPANDING FAMILY PRACTICE seeking BC/BE family practitioners to join thriving two-physician group. Excellent opportunity for potential partnership. Involved in both prepaid and fee-for-service practice. Competitive salary incentive program and full benefit package. Highly desirable area, practice environment in a dynamic South Florida community. Please send CV to: Mark A. Vacker, M.D., 4801 S. University Drive, Davie, FL 33328.

GAINESVILLE — FP, OB/ GYN, G/S, O/S (with fellowships), Psy. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

DAYTONA BEACH AREA, Florida. Immediate opening Walk-In Clinic. B.C./B.E., F.P. or E.R. Physicians, competitive salary, attractive incentives, excellent working conditions. Great place to live. Send C.V. to P.O. Box 703, Holly Hill, Florida 32017 or call (904) 258-5227, evenings (904) 673-0676.

NEED FAMILY PRACTICE or GP with ER experience for walk-in Medical Clinic with Integrated Hospital Practice in Fort Pierce Florida. Send resume to M. Viado, 4915 South Federal Hwy., Fort Pierce, Florida 33482.

WORKING VACATIONS! Top pay — Choice of positions — All specialties. Physician International, Locum Tenens Division, 4-FMJ Vermont Street, Buffalo, NY 14213, (716) 884-3700.

FAMILY PRACTICE seeking B.C./B.E. physicians for growing comprehensive practice. Fully equipped office. Family Medicine, 38111 5th Ave., Zephyrhills, FL 34248, (813) 782-9596.

SITUATIONS WANTED

GENERAL SURGEON, University Trained, Trauma Center experience. Desires position in Coastal area. Solo or HMO preferred. Available July '88. Send to: Florida Medical Association, Inc., P. O. Box 2411, C-1446, Jacksonville, FL 32203.

FAMILY PRACTICE Physician Florida Licensure Board Certified seeks position in Clinics, Public Health, also Locum, Tenens, Call (407) 878-6608 preferably evenings.

WOULD LIKE TO SHARE or sublet new office 1685ft.^{2} located in Wellington, W.P.B., adjoining the Hospital. For more information contact: (407) 832-7118.

BOARD CERTIFIED GENERAL INTERNIST trained at Jackson interested in working part time for solo practitioner or group in tri county area. Available for office and hospital call, weekends and possible weeknights. Currently employed in government health center under scholarship obligation. Possible future association. Send to: Florida Medical Association, Inc., P.O. Box 2411, C-1472, Jacksonville, FL 32203.

BOARD CERTIFIED GENERAL SURGEON. Florida licensed, wishes relocated to: Group, clinic, HMO or solo with coverage. Will do some general practice. Available now. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1486, Jacksonville, FL 32203.

PATHOLOGIST and PSYCHIATRIST. Husband and wife. Pathologist has Florida Medical license; Psychiatrist in application stage. Both board certified and experienced. Graduates of American Medical Schools. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1482, Jacksonville, FL 32203.

RETIRED BOARD CERTIFIED orthopedic surgeon seeks part time employment in Miami, FL area reviewing medical cases, hospital charts, quality assurance and peer review problems for hospital, state agency, insurance company or law firm. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1487, Jacksonville, FL 32203.

PATHOLOGIST 53 CERTIFIED AP/CP, hematopathology, nuclear medicine boards, Florida license, eight years experience in Florida, consider full or part time or seasonal. Needs 10 years more practice. Sent to: Florida Medical Association, Inc., P.O. Box 2411, C-1474, Jacksonville, FL 32203.

BOARD ELIGIBLE PATHOLOGIST, with six years experience in family practice, seeks opportunity to work in hospital, private group in pathology or family practice, walk-in clinic, public health. Reply to: Florida Medical Association, Inc., P.O. Box 2411, C-1479, Jacksonville, FL 32203.

ALCOHOL ADDICTION TREATMENT!! Board certified, experienced, Florida license. Extensive prior experience in internal medicine. Send to: Florida Medical Association, Inc., P.O. Box 2411, C-1476, Jacksonville, FL 32203.

BOARD RECERTIFIED FAMILY PHYSICIAN leaving busy practice in Miami to move to North Tampa, Palm Harbor area looking for part time position with flexible hours. Send to: Florida Medical Association, Inc., P.O. Box 2411, C-1478, Jacksonville, FL 32203.

NON-INVASIVE CARDIOLOGIST desires position in SW Florida. Association with cardiology group preferred. University appointment: Associate Professor, BC IM and Cardiology. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1484, Jacksonville, FL 32203.

I WANT SUNSHINE: Physician ASsistant from New York city looking to relocate to Florida. Experience in Emergency Medicine, Internal Medicine, and Family Practice. Call Rich ASAP (718) 339-0144.

PRACTICES AVAILABLE

YOU DESERVE THE BEST FROM YOUR PRACTICE. Call now for more information on our appraisal service. Sell with confidence. Call Frank B. Lane, M.D., Medical Director, M.C.A., 5121 Ehrlich Road, Suite 107A, Tampa, Florida 33624, (813) 968-3878.

OPPORTUNITIES FOR BE/BC Family Practice or Internal Medicine to take over a Family Practice located in Cape Coral, Florida. Please call George Grant at (813) 489-2227.

TWO RURAL FP practices and one suburban FP practice (all in Alabama) for sale. Profits are $200K. Modestly priced and owners will finance. Owners will introduce. P.O. Box 6002, Tuscaloosa, AL 35405.

FOR SALE S. FLORIDA OB/GYN PRACTICE, beautiful suite adjacent to hospital, patients easily transferrable, high gross, staff will remain for smooth takeover, pleasant community, perfect opportunity. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1483, Jacksonville, FL 32203.

PRACTICE FOR SALE — General Practice and Bariatries — 3 blocks from hospital, 4 examining rooms, parking, fully equipted. Retiring because of health. Hill Realty & Associates, Inc. (904) 428-6472 Mavern "Cherry" Hayes-Broker/Salesman.

RETIRING — Medical Practice available with fully equipped office - 25 years working office. Located in busy tourist area, minutes from Sheraton and others hotels and condominiums. Terms negotiable. Boards certification needed for close hospitals. Dr. Kaylan, 9573 Harding Ave., Surfside, FL 33154. (305) 866-8384.

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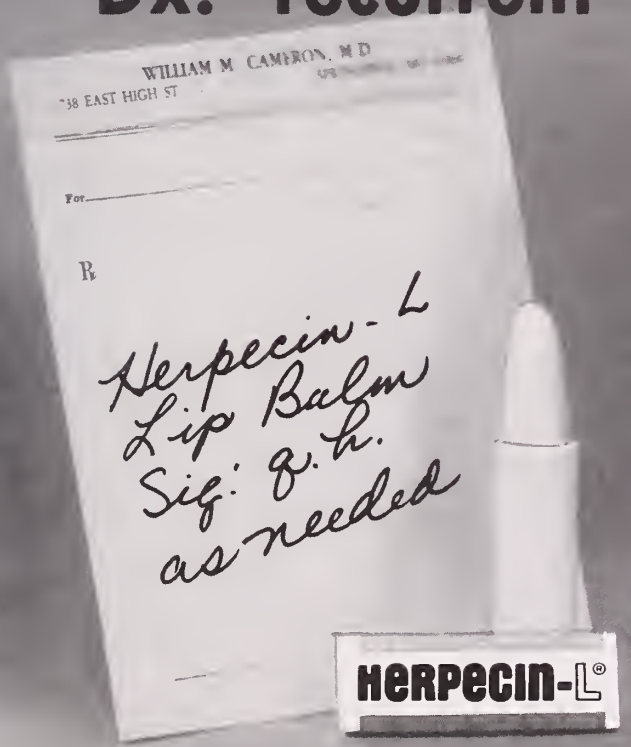

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Feature Editor — **Dale C. Havre, M.D.**

Doctors' Bills Should Be Simple and Easy to Understand

If patients do not pay their doctor bills on time, or do not pay them at all, sometimes it is not their fault. Physicians' billing systems are often confusing and, when Medicare is involved, the whole process can be a study in frustration. Take my word for it. For the past couple of months, I have been trying to help my aunt and uncle pay their medical bills. Because my uncle had been very ill with refractory cardiac arrhythmia, CHF and recurrent pleural effusions, the doctor and hospital bills mounted rapidly.

Almost daily another fistful of bills arrived in the mail. My aunt never could keep up with them nor could she ever distinguish between radiologists and pathologists. "But I already paid that bill!" she lamented as she opened the second-round billing from the radiologist, not realizing that she had paid the pathologist twice. My uncle, who normally handled the bills, was no longer able to help. He was too ill to participate in the process. That was truly unfortunate because after years of struggling with the vagaries of Medicare he had gotten pretty good at it.

When I volunteered to help, I didn't realize what I was getting into. What at first seemed to be a straightforward chore became a nightmare of confusion. For one thing, no two doctors' bills looked alike in format. Each statement had to be searched to find the literal "bottom line." On some bills it was in the lower right-hand corner, in others it appeared along the top of the page, and in some I never could figure out where it was.

Furthermore, whether or not the doctor had accepted Medicare assignment was frequently in doubt. When and if to file the coinsurance became a major dilemma. And trying to figure out some of those devilish return envelopes was worse than taking a practical exam in anatomy.

The one thing I was comfortable with in the bills was the medical terminology. My aunt was grateful to learn what a "thoracentesis" was, and she felt much better about shelling out the dollars for it (there was no Medicare assignment for that procedure, although the same physician had accepted assignment on previous visits). But she just could not understand the fee for a "cytologic dx, bx specimen," particularly when it came from a doctor "I don't even know." I assured her that the charge was very reasonable and the test was necessary, but how many patients have an in-house interpreter to help them unravel such mysteries? Finally, I am convinced that the so-called Explanation of Benefits memos that all insurance companies generate is the ultimate expression of the bureaucratic mind. Not only can EOBs be totally misleading but they also can drive the rational mind into a frenzy of despair. Disgust with the whole system is a common reaction to wading through a stack of EOBs.

I think we physicians concentrate too much on trying to bill patients more efficiently from our standpoint alone. Witness the evolution of computerized billing systems, complete with account aging right on the statements, and the plethora of cleverly designed return envelopes. But what we seem to forget is that patients, often not in good physical and/or mental condition to cope with our ingenious paperwork, must interpret and respond to whatever we send them. Why not make it easy for the patient to understand the statement? Similarly, the same considerations that inspired the birth and propagation of the standardized insurance claim form should prevail to encourage doctors to develop a uniform billing notice. We should make it simple and convenient to reply. A standard format could be adapted easily to most practices, and patients would be grateful to see similar items in similar locations on the bill. As I slugged through the mountain of medical bills my aunt and uncle received, I can tell you that the ones I paid first were the ones I understood the best. There should be a lesson there.

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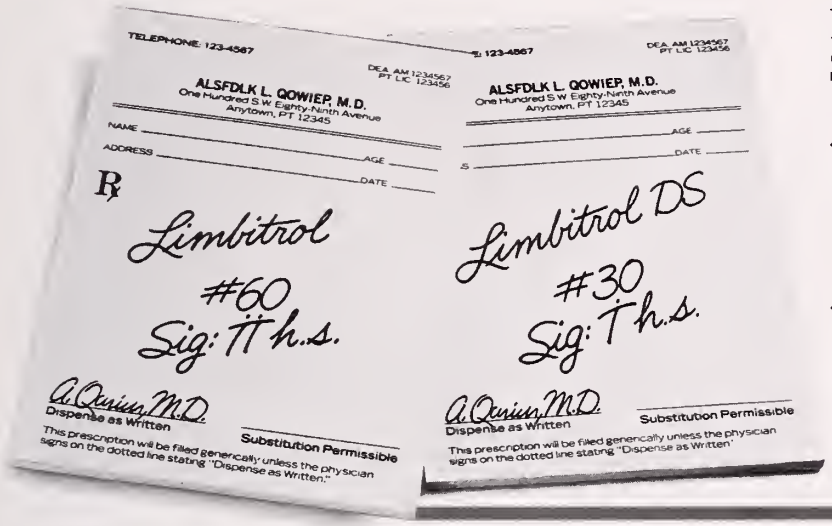
- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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- First-week reduction in somatic symptoms[1]

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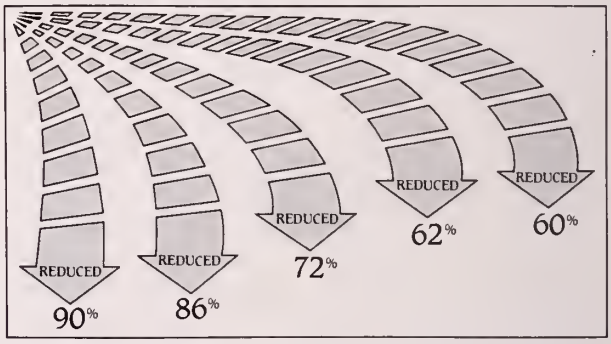

*Patients often presented with more than one somatic symptom.

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Historical Issue

W. C. Chowning M.D.

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PRNews

Published by the Physicians Recovery Network Committee / Florida Medical Foundation / P.O. Box 2411 / Jacksonville, Florida 32203

August 1988 "Doctors Helping Doctors" Vol. 4 — No. 2

PRN Family Component Offers Help to Spouses

The Medical Family Component of the Physicians Recovery Network is a resource for medical families that have a loved one or colleague who suffers from chemical dependency or emotional/mental illness. Contacts are confidential even within the medical community. Physicians and/or their family members who fear identifying themselves may call the Family Component anonymously for support, guidance and referral.

When problems exist in a medical family, it is often difficult to seek and find appropriate help. Any member of the medical family — physician, spouse or child — may call the Family Component for anonymous and confidential assistance in dealing with a loved one who is troubled. Often physicians are embarrassed and feel helpless when a family member suffers from drug or alcohol problems. A physician caring for the sick should be able to care for his/her own spouse or child; yet, often those closest to an ill person are the least able to help.

Many spouses are frightened and feel isolated when their physician spouse has an alcohol/drug problem. Their spouse is the diagnostician in the family. How can they, as lay people, presume to identify an illness in their professional loved one? Chemical dependency surfaces in the home life long before it becomes apparent in the medical setting. Yet spouses too often wait to seek help until the marriage has disintegrated; children begin to exhibit difficulties; or legal complications are occurring.

When a physician's wife has an alcohol or drug problem, the husband is likely to solve the problem by divorce. Unfortunately, the next relationship or marriage entered into by either of the former partners likely will encounter similar problems. Physicians and other health professionals are trained to control situations, and they expect to be able to fix things whenever they try. It is exceptionally difficult for them to cope with the personal failure to correct the problem and its effects. The appropriate specialist for referral concerning alcohol, drug or mental illness in the medical family is the Physicians Recovery Network and the Medical Family Component.

Most impairments can be treated, but not if they are covered up. It is especially tragic to let someone's career, family and health deteriorate from a treatable illness.

The Medical Family Component's telephone numbers are 1-800-888-8776 (toll free) or 1-904-277-8004.

Requests for fall presentations by the staff of the Program are welcome. We offer speakers and/or visual shows for interested groups such as county medical societies,

(Continued on Next Page)

DUI, Nicotine Addiction Talks On Chemical Dependency Program

AMA National Conference To Be Held October 26-30

The American Medical Association has announced preliminary plans for the Ninth National Conference on the Impaired Health Professional, which will be held at the Chicago Marriott Hotel, Chicago, Ill., October 26-30, 1988.

This multidisciplinary national meeting is sponsored by the AMA, the American Academy of Physician Assistants, the American Dental Association, the American Medical Association Auxiliary, the American Pharmaceutical Association, the American Podiatric Medical Association, and the American Veterinary Medical Association.

"Visions and Values" is the theme of this year's meeting, which will emphasize those comprehensive and responsive solutions that address the complex elements necessary for prevention, education, advocacy and research. July 1 was the deadline for submission of abstracts.

Bringing together key leaders from medicine and allied health professions, the conference gives participants an opportunity to question program innovators on what works — how, why and when. The program examines in depth the differing programs developed to meet diverse needs; fosters the development of collaborative efforts to make better use of existing resources; allows for the sharing of experiences and insights; identifies emerging trends and critical issues, and shapes policies.

In addition to lectures, the program will include research presentations, workshops, skill building sessions, case consultations, film festival, exhibits, hosted luncheon tables, intervention training, and self-help support groups.

Additional information may be obtained by calling toll-free 1-800-621-8335.

For the eighth consecutive year, the FMA-FMF Physicians Recovery Network Committee will sponsor a scientific Section on Chemical Dependency during the 1988 Annual Meeting of the Florida Medical Association.

The program will be presented from 1:00 to 4:30 p.m. on Wednesday, September 7, in the Mezzanine Theater of Hollywood's Diplomat Hotel, according to Program Chairman Lynn Hankes, M.D., of Miami.

Guest speaker Richard Irons, M.D., Medical Director of the Montana Physicians Assistance Program at Helena, Mont., will speak on "DUI—Doctoring Under the Influence".

Also speaking will be Roger A Goetz, M.D., Medical Director of the FMA-FMF Physicians Recovery Network. His topic is "PRN—What's New?"

The final speaker will be Dr. Hankes, who plans to talk about "Nicotine Addiction—No. 1 Affliction".

Guy T. Selander, M.D., of Jacksonville, Chairman of the PRN Committee for the past eight years, will welcome participants.

All physicians, spouses and others registered for the Annual Meeting are encouraged to attend. There is no charge.

PRN Office Moves to Fernandina Beach, Fla.

The Physicians Recovery Network office has moved to Fernandina Beach, Florida, approximately 40 miles northeast of Jacksonville.

The larger office space acquired in the move and the expanding administrative capability now provided by PRN insures that the increasing case load is administered expeditiously. The new case load has risen from 21 per month at the end of 1987 to 24 per month at the end of April, 1988.

Mailing address for the office is: Physicians Recovery Network, P.O. Box 1881, Fernandina Beach, Florida 32034.

The phone numbers are 1-800-888-8776 (toll free) and 1-904-277-8004. Office hours are 8 a.m. to 5 p.m. Monday through Friday. On holidays, weekends and weeknights assistance may be obtained by calling 904-277-8004. The answering service will refer the call to a staff member on call.

Advocacy Contract: Important Element in Recovery

A physician or other medical professional recovering from chemical dependency as a participant in the Physicians Recovery Network is required to sign an Advocacy Contract.

This contract, a major component in the recovering professional's continuing care program, provides the structure and the means to monitor the physician. Included are sections that insure the participant's practice and overall medical condition are monitored by fellow professionals.

Another section insures that the participant is monitored on a random basis through urine or blood testing. It produces evidence of recovery and documents a participant's drug free status. Treatment centers, doctors' offices, clinics, and hospitals serve as monitoring sites. They are located within reasonable distance of the participant's home or practice.

There are several important rules for collecting the blood or urine specimen. All samples are collected under direct observation and supervision. The protection of the participant's confidentiality is essential. Only the monitoring physician and the staff of the Physicians Recovery Network are aware of actual identity of the participant. In most instances a relatively low-cost substance screen will be used. In some instances more specialized screens conforming to the participant's history and current performance and behavior will be ordered. It is up to the participant to pay for all urine and blood tests.

The frequency of these screens is determined by the duration of the participant's recovery. For example, during the first six months of recovery, two screens per week on a random schedule may be adequate, after which the recovering participant will be placed on a random no-notice monitoring system. As in the early monitoring phase, the participants must report for the test within 24 hours of notification from the Physicians Recovery Network or the monitoring physician.

When participants fail to report as required, the screen will be assumed as positive, unless a negative is confirmed no later than 24 hours after the initial screen date. To insure ill-founded actions do not occur, the participant is urged to let the monitoring physician know prior to the screen what legitimately prescribed drugs are being used and the name of the prescribing physician.

No-notice screens may be ordered by the Physicians Recovery Network office or the monitoring physician if reports of behavior or practice problems are received. Changes in behavior patterns that have been established in recovery may be indicators that a relapse is imminent or may have occurred. A screen at such a time may indicate an active relapse, or prove that a relapse has not occurred.

A negative outcome results in further monitoring and developing measures focused on restoring the individual to recovery. When a negative urine screen serves as further evidence of the participant's continuing recovery, it is frequently considered favorably in board hearings or other administrative proceedings.

These screens do not supplant those that may be ordered in Board orders and penalties, nor are they intended to interfere with what hospitals do to insure their staffs practice safely without impairment.

Questions concerning this element of the Physicians Recovery Network system can be addressed to the Physicians Recovery Network office by phone or letter.

Cocaine Handbook Available from FMA

A recently published handbook for Florida physicians entitled "Cocaine — A Major Medical Problem" is now available through the Florida Medical Association office in Jacksonville.

The handbook was written by John C. Eustace, M.D., a member of the Florida Medical Association Committee on Substance Abuse and Clinical Director of the Mount Sinai Medical Center Addiction Treatment Program, Miami Beach.

The handbook is designed to increase a physician's awareness of the extent of cocaine use among patients and to help improve diagnostic skills in an area of medicine that is foreign to many physicians. Copies of the handbook can be obtained free of charge from the Florida Medical Association, Inc., at P.O. Box 2411, Jacksonville, Florida 32203.

Family Component (Cont.)

county medical societies, auxiliaries, hospital medical staffs, credentials committee, CME seminars, and medical school classes

A tape-book library and other resource material on addiction in the family has been established in the Physicians Recovery Network office by the Duval County Medical Auxiliary.

Support Groups

Support groups for medical professionals have been established in 16 Florida cities:

Pensacola	**Panama City**
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Information on how to contact a professional support group can be obtained by calling the PRN office, (904) 354-3397 or 1-800-888-8776.

Caseload Reaches 1,003 As of May 31, 1988

The total number of case files maintained by the Physicians Recovery Network Program has passed the 1,000 mark.

Between the beginning of the program in 1980 and May 31, 1988, the program opened files on 1,003 cases, according to PRN Director Roger A. Goetz, M.D., of Fernandina Beach. The number includes 176 that were opened before Dr. Goetz became the program's first fulltime director in 1985.

Seven Florida Facilities Approved for Treatment

Physicians and other health care professionals referred for evaluation and treatment by the Physicians Recovery Network or those who are self-referred are admitted to one of seven approved facilities in Florida or to an approved facility in another state.

The Physicians Recovery Network Committee has approved the following treatment facilities in Florida for participation in the program.

- Charter Glades, Naples
- The Friary, Pensacola
- Glenbeigh of Tampa
- Koala, Bushnell
- Mt. Sinai Hospital, Miami
- South Miami Hospital, Miami
- University of South Florida Psychiatric Center, Tampa

Provisional approval pending has been given to Anon-Anew at Boca Raton.

Treatment facilities affiliated with the Physicians Recovery Network through Mississippi and Georgia's Impaired Physicians Programs are among out-of-state centers used.

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COVER

Physician, politician, and humanitarian Dr. W.C. Chowning is a fitting symbol for this month's special historical issue of *The Journal*. Like many of his contemporaries, Dr. Chowning embodied the ideals of social responsibility and service to mankind through the practice of medicine. His story and others in this issue are tributes to an era worth remembering. (Photo courtesy of Dr. Chowning's daughters, Mary Lowell and Virginia.)

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PRESIDENT'S PAGE

It's Official — We Are on the Ballot!

I am pleased to announce that our Constitutional Amendment has now been officially certified by the Secretary of State for inclusion on the November 8, 1988, general election ballot as AMENDMENT 10. With more than 515,000 petitions collected, it is clear that Floridians are ready to respond to this issue. My personal thanks to each of you for your loyal support throughout the petition drive campaign.

Now we begin the most demanding phase of the campaign and your financial support is essential to inform the voting public on this crucial amendment.

With this issue now officially on the ballot, those who oppose the amendment — which include the Academy of Florida Trial Lawyers — will unleash a bitter campaign to oppose the amendment and spend large sums of money in an effort to defeat its passage in November. The Florida Committee for Liability Reform has already raised over $4 million for the campaign, primarily from Florida's health care community. The committee is seeking additional contributions from the business community and individuals to help finance the campaign which is expected to cost between $5 million and $6 million.

Therefore, the 1988 FMA assessment for professional liability is of crucial importance to help wage a successful campaign. My thanks to those of you who have already paid your assessment, and I hope you will encourage your colleagues to follow your example. If you have not paid, I urge you to do so as soon as possible. We need your financial support today. Extensive research carried out in recent months to measure the public's attitude regarding the professional liability issue in Florida reflects a broad base of support on which to build a successful campaign and a victory in November. However, it is essential that accurate and factual information regarding the amendment and what it will do be provided to the public to assure its passage.

The cost of this campaign will be tremendously expensive. We anticipate that it will cost between $5 and $6 million; however, the benefits will be tremendous. Stability and predictability will be restored to our tort system. Actuaries predict substantial future savings on liability insurance premiums as a result of enacting the cap. Additionally, 25 other states have already adopted caps on noneconomic damages, and premiums for liability insurance in those states are significantly lower than in Florida.

We also need your active participation in the campaign. Discuss the amendment with your patients and friends and volunteer to work for the FCLR as a spokesperson before groups and civic clubs.

With your personal commitment of financial support and active participation, we can win this battle to restore fairness, stability and efficiency to Florida's civil justice system and to protect the quality of life of all our citizens.

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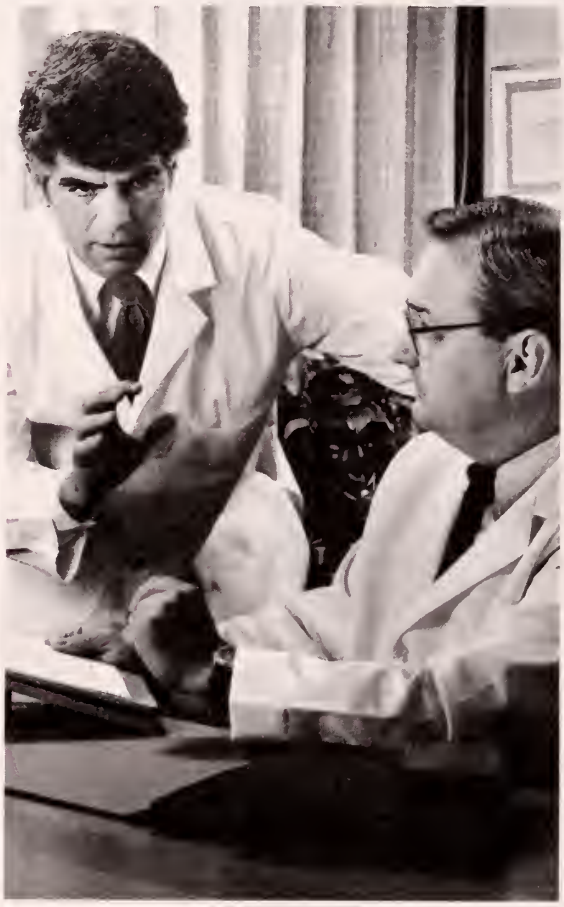

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EDITORIAL

In Search of Equity Amidst Unity

One potentially divisive issue in medicine is the long-held perception that double standards are used to reimburse physicians for their services. Most physicians recognize it as the old problem of cognitive versus procedural services. Primary care physicians, particularly general internists and family practitioners, have for sometime been campaigning hard to correct what they feel are deeply-entrenched inequities of the current reimbursement system. No drastic overhaul of the system has happened yet, but Medicare and other third party payers are increasingly recognizing that some surgical and procedural services are indeed overpriced, while many common nonprocedural services are undervalued. The preliminary findings of the resource-based Harvard Relative Value Study appear to confirm that this is the case.

Physicians have to be blind not to recognize the glaring deficiencies of the current reimbursement system. Simple procedures which take no more than 15 or 20 minutes, sometimes less, fetch handsome rewards which are grossly out of proportion when compared to the meager payments being doled out for nonprocedural services. Even when one considers the length of training, the relative risks of the procedures, and the costs of equipment, it still does not make sense to put so much premium on procedures at the price of having to undervalue equally valuable but nonprocedural medical services.

It is absurd to think, for example, that a physician taking care of a patient with an acute MI for one week is going to get less compensation than another physician who slips a tube into the stomach and gets the procedure done in less than 30 minutes. But that, in fact, is the case. Numerous similar examples can be cited but they all exemplify the aberrations of a system that badly needs to be revamped.

In response to the increasing demands to establish more fairness and to do away with the inequities of the system, the HCFA has already identified a number of procedures which it felt are "overpriced" and which are now being targeted for reductions in reimbursements. Some major recommendations of the Harvard Relative Value Study, if adopted by Medicare and other insurance companies, would reduce payments by as much as 30% for certain procedures while boosting those for a number of cognitive or nonprocedural services.

The efforts by the American Society of Internal Medicine, the American Academy of Family Practice, and the American Academy of Pediatrics to establish more fairness and justice in the way physicians are reimbursed should not be viewed as an affront to their surgical colleagues and other procedure-oriented specialists, nor as a sign of an internecine struggle where one group is trying to denigrate the value of the services of another. Rather, they should be viewed as a cooperative effort by the entire profession to correct historical inequities and to place every physician on an equal footing. Anything less than a united effort will hurt the cause of our profession.

The president of the AMA, Dr. James E. Davis, articulated well the need for unity among physicians in dealing with the problem of physician compensation. He said: "If we fail to stand together to give the RVS concept a chance to succeed, we may be squandering our last chance to create, by ourselves, a workable solution to the issue of physician compensation. Heaven knows, there are plenty of others who would like to put forth their own solutions."

We need to pay heed to those words. Dissension within the ranks of medicine will drive a deep wedge that will fragment the profession forever. The examples of Great Britain and Canada should drive home the point that a divided house of medicine is an easy prey for the government. The long-awaited release this month of the Harvard Relative Value Study and how physicians across the country view the findings will be the first test of whether they can unite for their salvation, or divide for their destruction.

R. G. Lacsamana, M.D.
Editor

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LETTERS & VIEWPOINTS

Legalizing Drugs Is Humane and May Work

In regard to your editorial denouncing the legalization of drugs, I read it with bated breath hoping that somewhere in the dissertation I would find a counterproposal offering a workable solution for reducing the country's appetite for drugs. Unfortunately that did not appear anywhere. To my mind there has not been a good study done to indicate why so many of our young people get hooked on drugs, but I feel from my observation of my patients and even my own experiences as a youth that doing something slightly illegal is a very titillating experience when you're on the verge of adulthood and want to rebel against society a bit. Therefore the illegality aspect has a big drawing power for many.

Secondly, it should be pointed out that in the early part of our history, opium reigned as the one chemical in most physicians' armamentarium that was useful and predictable in its effect, and it was a component in a large percentage of all the medications dispensed both over-the-counter and by physicians, thereby making it the most widely used nostrum utilized. The number of addicts to opium was not any greater than later when a strict control was imposed. A great percentage of the people who were harmed by opium were children whose parents administered it with the vain hope of controlling their "colitis" and to offset the effects of "teething". Therefore, I don't think anyone can say with any certainty, as you stated in your editorial, that the amount of drug addiction would rise if drugs were legally available.

There is one situation that is often cited concerning the experience in England where addicts were given access to whatever drugs were required to keep them comfortable and help them function. This system was brought to its knees when a clampdown was imposed on addicts in other parts of the world who flocked to England in order to obtain drugs but did not bring with them the necessary means of obtaining livelihood and, thereby, overburdening the welfare system. It would certainly seem that a program in this country where the true addicts were given enough medication to let them function as decent members of society and not have to pay exorbitant sums for illegal drugs would benefit all of us from the fewer crimes that would result.

In addition, I think we should all keep in mind the experiences of William Halstead who became a cocaine addict when he was experimenting on himself in an effort to derive at a technique of providing regional anesthesia for his patients. He was unable to rid himself of this addiction even though some well-meaning friends kept him on a sailboat for a year at his own request and cooperation. However, he did learn that he could be comfortable on morphine and during the time he did some of his most brilliant work he was requiring 80 to 100 mg morphine daily in order to function. It would seem expedient to try to ward off addiction by education as much as possible but try to deal with the "hard" drug addicts as humanely as we ought to do with those unfortunate people addicted to alcohol and nicotine.

Van Parker, M.D.
Sanford

Editor's Note: My editorial focused mainly on the reasons why legalizing drugs would not work. Stiffer penalties against both drug dealers and users, tougher policies including the use of economic sanctions against countries supplying us drugs, and more sustained and sweeping interdictions will help cut both the supply of and demand for illegal drugs. Education and rehabilitation are important, but we also need to question whether the liberal, bleeding-heart approaches of the past are relevant to the problems of the present.

Dr. Parker may feel that what is illegal may titillate people, but a lot of us are not any less titillated when alcohol was made a legal substance. That will be true with marijuana, heroin, and cocaine. The example of Halstead cited by Dr. Parker also sounds fallacious in the context of the broad sweep of problems we have today.

Daddy, Tell Me a Ghost Story

Once upon a time, a trillion years ago, in the Ever-Ever Land of Uz, there lived a Casper named Ghost. Now this Casper was over 300 years old and, therefore, under Public Law Such and Such qualified for Cedimare. The Loctors practicing under the Cedimare system were so harried, harassed, and hurried serving on the Mutilization Beview Road of the Yocal Fospitals, filling out umpteen dillion forms for said hillions of patients that they could devote only a small portion of each minute to diagnosing, treating, and consulting with said patients. Herefore, to put it mildly, the Cedical Mare was not of the optimal quality

so that in time, this poor 300 year old Casper died and went to Earth.

In due time, Ghost reached the qualifying age of 65 and so became a patient under PL 89-97, commonly known to both the initate and the uninitiate as Medicare. The system, to put it mildly, was not of the best. The doctors were so busy filling out form after form, corresponding daily with Medicare headquarters as to why this patient should be hospitalized for 10.2 days rather than 4.7 days or why that patient had to be placed in an Extended Care Facility, serving on a Utilization Review Board at a local hospital, and occasionally being summoned before a Peer Review Committee, that they could afford only a small portion of time for their patients. So, as said before, the system — and medical care — was not of the optimum. Hence, soon after reaching the qualifying age of 65, poor Ghost expired.

Of course, the moral to all this nonsense as anyone can easily see is that no matter how you slice it — or where — it's still baloney. Or, put another way, there is no such thing as a free lunch. Ljork fdmm and ldjr.

Arthur F. Schiff, M.D.
Miami

Editor's Note: Whether you call them baloney or not, I am always terrified of ghost stories. They give me goose bumps and an uncontrollable desire to choke the nearest bureaucrat.

Selected Reflections on Hepatobiliary Disease

I only know what I have seen — Ernest Hemingway

In 1980 I depicted some highlights in the field of jaundice observed during a period of five and a half decades.[1] I emphasized the outstanding importance of the van den Bergh test, the epoch-making studies in hepatectomized dogs on the formation of bilirubin, and the conjugation of bilirubin. I pointed to the folly of the concept of catarrhal jaundice — now recognized as viral hepatitis — as resulting from a plug of mucus obstructing the common bile duct and the wisdom of discarding the therapeutic application of transduodenal biliary drainage. A comprehensive study of a patient with Rotor's syndrome[2] was included, which led to a much wider recognition of this rare disorder.

I have followed the case of a former colleague in whom I made the diagnosis of Gilbert's syndrome 60 years ago. He has remained free of recognizable biliary tract complications.

I have long been impressed with the dictum of Franklin Hanger expressed to me in a friendly chat: "One good feel of the liver is worth any two liver function tests." I have found that the first feel is often the best because flipping the liver edge may be painful and prevents the patient from taking a full breath for the second attempt. Even when the liver has once been palpated, repeated examinations during a given hospital stay are advisable and may provide a more accurate indication of its configuration and texture. The time devoted to the abdominal examination, the patient's cooperation and variations in the examiner's perceptivity may influence interpretation of the abdominal findings.[3] Gentle, rather than deep, palpation may prove more revealing to the examiner and less discomforting to the patient. Directing the patient's thoughts to some unusually pleasant past experience is often helpful in promoting abdominal relaxation. I have long been a staunch advocate of Osler's aphorism:[4] "Don't touch the patient — state first what you see; cultivate your powers of observation". After all, a Courvoisier gallbladder may be more visible than palpable and has been known to present itself in the right lower abdominal quandrant. I recall once seeing the outline of a stomach distended by pyloric obstruction which had been missed on roentgen examination.

Nowadays it is realized that primary biliary cirrhosis remains asymptomatic for years. I have followed several such patients including a middle-aged woman in whom a diagnosis was made ten years earlier. A needle biopsy of the liver repeated eight years following the initial one revealed no progressive changes. Jaundice has actually proved a late manifestation, suggesting a guarded prognosis.[5]

A marked increase in serum transaminases may be found exceptionally in obstructive jaundice[6] and leads to a diagnosis of viral hepatitis. I have witnessed a number of such instances in patients with pancreatic cancer. Such increases are apt to fall more rapidly than those in viral hepatitis and have been attributed to hypodermic injections of morphine with resulting spasm of the sphincter of Oddi.

I recall presenting a deeply jaundiced elderly man with a readily visible nontender distended (Courvoisier) gallbladder as a classical example of carcinoma of the head of the pancreas, only to learn to my embarassment, that his icterus was due to a common duct stone. Profiting by this experience, my fellows correctly made the diagnosis of common duct stone in a second similar case. The third time around I stuck to my original diagnosis which unsurprisingly proved correct. The classical paper of Flood and his associates [7] showed that in one fourth of their cases of common duct stone "there was enlargement of the gallbladder at operation" and "in most of these the

gallbladder had been accurately palpated before operation".

I have witnessed unusually prolonged survival following serious complications in alcoholic cirrhosis. I attended a prominent business executive who survived a bout of hepatic encephalopathy. Following alcohol withdrawal, he remained very productive over 23 years before succumbing to a myocardial infarct. A second patient, a physician, had an emergency transthoracic transesophageal ligation of bleeding esophageal varices performed by Dr. Robert Linton, followed in two months by a proximal splenorenal anastomosis. He later survived an episode of bleeding peptic ulcer and was reported feeling well 13 years after the operation. Some years ago Franklin Hanger told me of a documented case of cirrhosis with a 40-year survival.

In January 1980, a Peruvian male, age 23, was referred to me because of a family history of hepatoma complicating chronic B viral hepatitis contracted perinatally.[8] A sister age 19 and a brother age 23 died of hepatoma, the diagnosis having been confirmed at laparotomy. He was asymptomatic and the physical examination was negative except for a palpable spleen extending 1 f.b. below the left costal margin. The possibility of hepatoma was considered only because of the family history. A left hepatic lobectomy was performed by Joseph Fortner at the Sloan Kettering Institute for Cancer and Allied Diseases on February 10, 1980. The tumor was measured by the pathologist as being 20 x 11 x 15 cm; yet the liver was impalpable, though actually not contracted in size. The patient was alive and reported to be well seven years later.

The employment of needle biopsy in the differential diagnosis of jaundice has declined markedly, chiefly because of the difficulty in distinguishing intrahepatic from extrahepatic cholestasis and the contributions of hepatobiliary imagery. When extrahepatic cholestasis has been included, one should suspect drug-induced hepatoxicity.

While serious bleeding is most apt to manifest itself within six to eight hours after the procedure, I recall one patient whose bleeding became evident 48 hours later. He had been discharged from the hospital, as was customary, on the day following procurement of the biopsy specimen. In another instance, a rigid tender abdomen noted two days after needle biopsy and thought to be due to bile peritonitis proved to be caused by a perforated duodental ulcer.

I have occasionally found it helpful in getting the patient with alcoholic liver disease to abstain from further indulgence by emphasizing the fact that I had seen a specimen of his liver and was therefore in a better position to know that further indulgence in alcohol would prove most harmful. I was pleased to learn that Worth Boyce offers the same advice after his "look at the liver" through the laparoscope.

In spite of the advances contributed by hepatobiliary imagery, the images are often nonspecific. For example, a blood clot may simulate a common duct stone[9] as may a ductal neoplasm.[10] Iatrogenic stenosis of the junction of the hepatic ducts may be indistinguishable from Klatskin tumor. A carcinoma of the gallbladder enveloping the hepatic duct may mimic a bile duct tumor.

Because of these pitfalls, efforts should be made to obtain permission for a necropsy in cases in which surgery is contraindicated because of poor risk. Information thus obtained can only broaden the experience of the attending physician and confidence of the surviving family.

Since joining the staff of the Center for Liver Diseases at the University of Miami in 1970, I have become impressed with the usefulness of laparoscopy, let alone its advantage in affording a guided needle biopsy, which in experienced hands makes the risk no greater or perhaps even less than in blind biopsy. It may reveal cirrhosis in the face of normal LFTs and even a negative needle specimen. In two alcoholics with icterus and ascites suggesting the presence of cirrhosis, laparoscopy revealed a congested liver, which in turn led to detection of unsuspected constrictive pericarditis.

I would like to express my thanks to my devoted family and to God for sustaining me over the years and enabling me to record these observations. And my thanks to William B. Bean for reviewing this manuscript.

(References available upon request)

Leon Schiff, M.D., Ph.D.
Coral Gables

A Plea for Euthanasia

The National Hemlock Society founded a new chapter in Jacksonville last month, the seventh to be founded during the last four months throughout Florida. The purpose of Hemlock is to have legislation considered and passed in Florida and three other states (California, Washington and Oregon) by 1990 that would permit physician aid in dying otherwise known as euthanasia.

Many physicians feel threatened, or at least uncomfortable, with the thought that terminally ill patients whose condition is deemed irreversible could request physician aid in dying — a lethal injection probably — and the physician would be called upon to "kill". No doctor would be forced to do this but it would become legal and, later, it would be expected.

But before uniting against this proposed legisla-

tion, and although physicians run too many risks already in their constant battle against death, consider the present practice of **prolonging death.**

Here is the real issue: we can prolong death or we can ease death as the patient wishes. And once condemned to death by a terminal condition, has the patient no rights and have we no mercy, no empathy? Of course, prolonged death is far more profitable than eased death, but shall this be our main concern?

A woman of 73, diabetic, called Hemlock last week desperate to end her life. Gangrene had been diagnosed and she was to have an amputation within days and this was to be the first of a series. She will die after an unknown number of such operations and between operations how will she "live"? Is that a life that must be prolonged at all costs **against her own will?** Or is it a hideous prolongation of death? Profitable, of course! So her physician can righteously repeat, "I will never kill!"

Physicians uniting against the principle of physician aid in dying legislation face some real hostility on the part of a public that is rapidly becoming more and more aware of the profitability of prolonged death, a public that is already considerably alienated by their incorporated doctors. Very soon, the "I-will-never-kill" physician will be answered in the press and on the air by the rejoinder: "Of course you won't: it is not profitable for you to show mercy — and common sense."

Eighty percent of all people die in institutions. A death prolonged by a year at $500 per day must be compared to a death eased in one day — compared by the management of such institutions — and by the physicians.

When the hue and cry over the "Debbie" article in the JAMA died down, it was found that a month later there was a preponderance of letters to the editors of JAMA reflecting agreement in principle with the admittedly fictitious young intern's action.

As physicians unite in a common cause, let the cause be one of mercy, of humaneness, of true morality that is based on allowing patients their own rights, of honoring their own choices and decisions in the face of their own pain and fear of suffering, indignity, helplessness.

I want my doctor to be my trusted, knowledgeable, and dependable friend in my old age — not my impersonal, profit-seeking guardian at my expense.

Henry L. Brod, Ph.D.
Sarasota

Editor's Note: The problem of euthanasia is almost as old as the biological fact of death. The ability of modern medical treatment to prolong life even in terminally ill patients, and at tremendous economic costs to society, has generated renewed and passionate debates on the subject. There is no simplistic solution concerning euthanasia in the face of an intertwining complex of medical, legal, moral, and philosophical questions surrounding the subject.

I vigorously reject Dr. Brod's contention that prolonged treatment of terminally ill patients is economically motivated. Dissemination of such willful misinformation will not advance the cause of the Hemlock Society nor endear Dr. Brod to physicians who are searching for medically sound decisions that are also legal and ethical.

The AMA has repeatedly stated that euthanasia is contrary to the interests and policies of physicians.

Housecleaning in Medicine Needed

I read your editorial, "The Wrong Prescription", with interest and a certain amount of nostalgia. I am one of the physicians who was practicing before the advent of Medicare. Many of us appeared before organizations such as business and civic clubs and on television at the local level trying to convince the public that once we had Medicare we were well on the road to universal health care. As you are aware, we were not successful in our plea. There has been a gradual invasion of government into the private practice of medicine; it has been slow but relentless.

When Claude Pepper was our Senator from Florida, he spoke before the Duval County Medical Society advocating more government involvement in medicine. I remember his parting remarks when he realized he had a hostile audience, "I don't care whether you agree with my ideas on socialized medicine, we are going to have it and I will still be your Senator from Florida". He was right about the socialization of medicine but he was not right about continuing to be our Senator. The Florida Medical Association together with a most active auxiliary went to work and defeated "old Claude" at the polls. In honesty, I must say the man who replaced Pepper was a disappointment as he soon became a close friend of the politicians with the "give away" philosophy.

As is the case in most issues, there are two sides to the problem. When I stopped the active practice of medicine after some 30 years, I became Vice President and Medical Director of Blue Cross and Blue Shield of Florida. This opened my eyes to a side of medicine that I did not know existed. I was naive. I thought that most physicians displayed impeccable integrity in their practice. By and large this is true, but a small percent of less than honest practitioners make it difficult for the rank-and-file physicians trying to practice medicine in an honorable manner. Physicians who have volunteered to work on claim committees, peer review committees, insurance committees or grievance committees for the county or state organiza-

tions have had a rude awakening to the activities of some of their colleagues.

"Cost containment" is for the other fellow. All visits are coded the most comprehensive. All lesions are of the most complex nature and repair is the most meticulous. Surgical procedures are fragmented into many codes as if each step was an operation unto itself. Many procedures of a cosmetic nature, not medically necessary are being performed and the patient is told Medicare will cover the cost.

I agree with you wholeheartedly that we do not need universal health care but are we as physicians doing our part to convince the public that universal health care is not the answer? When a patient receives his bill from a physician or a printout of his hospital bill that unfolds all the way across the room, he is prone to wonder: "Maybe we should have universal health care, these charges are ridiculous!"

Like "hot chicken soup", a little house cleaning wouldn't hurt.

Thomas M. Irwin, M.D.
Jacksonville

Editor's Note: I agree with Dr. Irwin, we need to go after the "bad guys" in medicine. There are not many of them, but they sully the entire image of the medical profession. It would not hurt to put some of them behind bars to let them know that we mean business.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis.*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known, once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired, concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients:

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness, therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C:

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations,* manic reaction, *irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema,* edema of the face, *neck, lips,* conjunctivae or *hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum.

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception,* overbrightness of *lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

For further information, contact the Miles Information Service: 1-800-642-4776. In VA. call collect: 703-391-7888.

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg *B.I.D.*
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg *B.I.D.*

COMMITTED TO THERAPEUTIC EFFICIENCY

MILES

Miles Inc.
Pharmaceutical Division
400 Morgan Lane
West Haven, CT 06516

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"Living in the city is lonely enough... with herpes it's like solitary confinement."
ZOVIRAX®
(acyclovir)
CAPSULES
Prevent genital herpes recurrences month after month with daily therapy.
(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)
Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRAX CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/vomiting, vertigo, and arthralgia.

The physical and emotional difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes, as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next page.

Prevent recurrences month after month*

ZOVIRAX® (acyclovir) CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psycho-social difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤ 10 ml/min/1.73 m^2.

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200" - Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Burroughs Wellcome Co., Research Triangle Park, North Carolina 27709

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Transderm-Nitro®
nitroglycerin
2.5 mg/24 hr, 5 mg/24 hr, 10 mg/24 hr, 15 mg/24 hr
Helps angina patients get more out of life
Significantly reduces both the frequency of anginal attacks and the need for sublingual nitroglycerin[1]
Preferred by patients over 7 to 1 for convenience compared to their previous long-acting oral nitrate; only 12% had no preference (n = 4,300)[2]
All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.
Please consult Brief Summary of Prescribing Information on the following page.
CIBA

Transderm-Nitro® nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area.
Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone. The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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Medicine in Florida, Varied and Colorful

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor

Medicine in Florida has produced a colorful and exciting heritage. It is rewarding and fulfilling to review some of our early predecessors, their armamentarium, modes of treatment and the compassion which seemed to encompass and transcend all their actions. In this issue we have several very interesting vignettes. There is Dr. Mary Marshall Man's story of an early physician along the central east coast of Florida which gives us a rich and interesting narrative of not only his medical life and practices, but also life along the Indian River in the late 1800s. From the other side of the state there is Karen Davis' poignant and emotional account of a young man's illness which almost claimed his life and a physician's dedication to taking care of that patient. This narrative is remarkable not only for medical details but also the emotions of the family of the young patient. While physicians continue to see difficult cases, not often are we faced with watching a patient die from an unknown diarrheal disease which almost happened with this young man. It is a very detailed account of the illness, the emotions, and the eventual recovery of this patient.

Dr. Ashby Hammond's article on the history of medicine in Florida in the mid-1800s is part of a larger work in which he is engaged and hopes to present in book form in the near future. He has spent many years collecting the history of individual physicians throughout the state. This is only a small part of that work and gives us an overview of medicine in the state during the 1850s. This small segment is enough to whet all readers' appetites to read the larger work when it is published.

I have included a short article on a physician who practiced on the east coast of Florida. He caught my interest not only because he is from my home town but also because he is quite typical of physicians in the past. Dr. W.C. Chowning was a physician who was also a politician, a public servant, and one of many physicians who have served in the state legislature. In the present day and time we have a dearth of physicians in the legislature and this, of course, is due to many reasons, but it is refreshing to review those physicians who served both as a doctor and a public servant.

I think the reader will find most interesting the story of poliomyelitis in Florida. The ravages of this disease are well known but have been largely forgotten by present day physicians who have been in practice since the 1950s. Kathleen H. Arsenault has written a very interesting and informative study of this terrible disease which periodically swept Florida during the warm months of the year. Lastly, we have included an article on the history of hysterectomy by Dr. Guy Benrubi. We, of course, realize that this subject is not confined to the history of medicine in Florida which is usually the practice of the historical issue. However, it is very interesting and there is no way to limit the history of a subject such as this to one state. We believe that readers will find Dr. Benrubi's article interesting and, since it is historical, we have decided to include it in this issue of the FMA Journal.

H. Frank Farmer Jr., M.D., Ph.D.
Historical Editor
New Smyrna Beach

W.C. Chowning, East Coast Physician/Politician

H. Frank Farmer Jr., M.D., Ph.D.

In today's world of medicine with hectic schedules and technological advancements, it is sometimes good to think about less tumultuous times, times in which physicians integrated more into society. They traditionally have been a part of the political process of the society in which they lived but it seems that in the last few decades physicians have not been as willing to participate in the political process or run for public office. There has been a dearth of physicians serving as mayors, city commissioners, and state legislators. The reasons are many, not the least is that it is an economic sacrifice to serve the public.

In the past physicians have been leaders in society and during the early 1900s it was not unusual for many of them to serve on city commission boards and the governing bodies of other municipalities as well as to be represented in state and national politics. Such a man was Dr. William C. Chowning, a citizen-physician in New Smyrna Beach, Florida, from 1909 until his death in 1954. Dr. Chowning was a typical physician who participated in all community affairs, served on various boards and was a member of the Florida Legislature. He did this at an economic sacrifice for himself and his family but felt strongly that physicians were endowed with a social responsibility and should make the time and the financial sacrifice to serve the community and the people with which they were involved.

W.C. Chowning, M.D. (1931)

The Author
H. FRANK FARMER JR., M.D., Ph.D.
Dr. Farmer is Historical Editor of the Journal of the Florida Medical Association and practices internal medicine at New Smyrna Beach.

Early practice ● Dr. Chowning was born in Merry Point, Virginia, in 1881, an only child. There were no other physicians in his immediate family so it is not known how he developed an interest in medicine. However, he decided early in life that he wanted to be a physician and matriculated at the University of Maryland, graduated and stayed on to receive his M.D. in

1904. He served a year internship and continued as a resident in obstetrics for another year. After the year of obstetrics Dr. Chowning was encouraged to come to Florida and begin a practice in Hawthrone, a small town located near Gainesville. The only physician there was leaving practice and the town would be left without a doctor. Dr. Chowning talked with several town leaders who encouraged him to come, and in 1907 he opened up a solo practice. He was in a general practice at that time and remained in Hawthorne for two years.

During that time he returned to Merry Point to marry a young lady whom he had known for many years. He and is bride returned to Hawthorne and stayed there until 1909. That year Dr. Chowning was asked to come to Daytona Beach to take over the practice of a Dr. Rawling, who was leaving for a period of time. It is unknown why Dr. Chowning and his wife, and by that time a baby girl, wanted to leave Hawthorne, but in 1909 they came to Daytona Beach and he practiced there for one year. He had planned on staying in Daytona Beach indefinitely, but a year later Dr. Rawling announced his intention to return and Dr. Chowning thought it would be unethical to remain in the area after covering for the physician for the one year. He moved his practice to New Smyrna Beach, 20 miles south. At that time there were only a few doctors in New Smyrna. It was a small community with the largest industry and population being associated with the Florida East Coast railroad. There was Dr. David Forster, a surgeon, who operated a small hospital in Hawks Park, which is now Edgewater; a general practitioner, Dr. L. Bouchelle, who was in solo practice and dabbled in real estate on the side, and a Dr. Fox who had come to the state in the late 1800s and was a general practitioner.

Dr. Fox had come to Florida when it was very sparsely populated and originally settled south of Eldora, on the beachside. At that time mosquitoes were terrible and it was a very hardy person who could live on the beachside, but Dr. Fox did and made house calls by horseback up and down the coast. He traveled as far south as Titusville and as far north as St. Augustine. Dr. Fox got interested in the use of palm tree berries for a cough syrup. He found that by crushing the berries the juice could be extracted which had a medicinal purpose as a cough syrup. He developed a small industry using the berries and this became the basis for a rather large scale industry in the late 1800s around Eldora.

When Dr. Chowning arrived in New Smyrna Beach, there was a dentist, who like Dr. Fox had practiced in the area since the late 1800s. Dr. H.B. Hawley had come in the 1880s. There was a shortage of dentists up and down the east coast and Dr. Hawley built his office on a boat in the Indian River and could travel as far south as West Palm Beach and as far north as Jacksonville doing dental work.

Community service ● At the time there was no hospital in either the New Smyrna Beach or Daytona Beach area other than private ones. Surgery was done by Dr. Forster in his hospital in Hawks Park. Dr. Chowning ran a general practice, did minor surgery in his office and made house calls with delivery of babies being a prominent part of his practice. His two daughters remember that at times it was a rather precarious existence financially and Dr. Chowning often had to depend upon his contract with the Florida East Coast railroad, which designated him as a contract surgeon. At that time the railroad was the largest employer on the east coast of Florida and had established a hospital in St. Augustine. The employees could use the hospital and the physicians in the hospital at a very nominal charge for the services. It was not unusual for employees and their families to get on the train in Miami and ride to the hospital in St. Augustine for treatment either as an outpatient or as an inpatient. Many of the employees around New Smyrna Beach took advantage of this service. However, the railroad recognized that there would be minor emergencies when it would be less expensive for people to be treated locally rather than take up a seat on the train and come to St. Augustine. For this reason it established a policy of contracting out to local physicians and they would be paid a certain amount of money per employee for each illness. Dr. Chowning was one of the contract physicians, which helped economically, especially during the depression of the 1930s.

Dr. Chowning practiced throughout World War I and did not serve in the Armed Services because he was disabled with the influenza which swept the country in 1917. His daughters remember him being very sick and close to death during that period. He continued to practice after the war in New Smyrna and became interested in local politics. He served on the school board as an elective representative and also was elected to the City Commission in the 1920s. He served several terms as a City Commissioner and at least one term as mayor. One of his main projects was to see that streets were paved in New Smyrna Beach; he was successful in getting the first paving done in the city. Prior to Dr. Chowning serving on the City Commission all roads were shell and the 1920s saw the beginning of paved streets throughout the community. He also was active in church affairs and served on the board of deacons for Christ Congregational Church almost from the time he arrived in town until his death.

Because of his interest in local politics, several prominent members of the community urged him to run for the Legislature and in 1930 he was elected to the Senate. He served one term until 1934. His daughters remember that it was a tremendous financial hardship even though the Legislature only met every other year. They remember Dr. Chowning having to spend almost four months a year in Tallahassee because of special sessions during the early 1930s. His

practice suffered greatly and many patients drifted off to other physicians because he was simply not available. At that time there were less than 40 senators and three of them were physicians. There were many physicians across the state who felt, like Dr. Chowning, that it was their responsibility and duty to serve in roles of government.

Economic hardships ● After one term in the Senate, Dr. Chowning believed that he would not financially survive if he served another term. The 1930s were a very hard time for physicians as well as citizens all over the country and New Smyrna Beach was no different. Many patients were unable to pay and payment, if given, was often in produce or in-kind services. However, Dr. Chowning continued to make house calls and deliver babies without regard for patients ability to pay. For those who could pay, the charge for nine months prenatal care and delivery was $35. All laboratory work done in the office was sent to a Jacksonville laboratory and took three to four days to come back.

As a result of economic hardships of the depression, the only private hospital in New Smyrna Beach closed. This left no hospital in the area and Dr. Chowning turned his home into a hospital with several beds. He hired help, and people were treated for various infectious diseases and other medical problems. He continued to operate the hospital until the 1940s.

When World War II came in 1941, Dr. Chowning and another physician were the only ones left in the town; the other physicians were called to active duty. He spent most of the war examining applicants for the Selective Services system and serving in various civilian capacities with air defense, bond drives, etc. After the war several more physicians came to the area and another private hospital opened up in town. At this point Dr. Chowning closed his hospital; he felt the need was being fulfilled. However, as other physicians came, he realized that a public hospital would be most desirable and he campaigned tirelessly to get a tax supported hospital for New Smyrna Beach. He suffered a myocardial infarction in 1948 and treatment at that time was to be kept in bed for almost a year. He did come back and practiced on a part-time basis until his death in 1954 in the hospital which he had helped to obtain as a tax supported institution.

His daughters remember Dr. Chowning as a very amicable individual who believed that patients should be cared for regardless of their ability to pay, and that physicians had a moral and ethical responsibility to participate in all walks of life even if it meant personal sacrifices in time and money. In that regard Dr. Chowning was like many physicians of his time and represents an ideal which the medical profession is hopefully returning to today as more physicians get involved in public participation and public service.

Acknowledgment

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● Dr. Farmer, 405 Downing Street, New Smyrna Beach 32069.

A Victorian Mother's Vigil Over Her Sick Son: Emma Gilpin's Journal of 1888

Karen Davis

Emma Gilpin's journal of 1888, written in Osprey, Florida, provides us with a rare glimpse of 19th century medicine through the eyes of the patient's family. While medical textbooks and physician's account books reveal the facts of medical history, this journal records not only medical practices but also one mother's concern for her sick child. The medical treatment may be outmoded, but Emma Gilpin's anxieties and the way she looks for signs of health or illness in her 14-year-old son are constants — easily understood and shared by mothers today.

John Robinson Gilpin, a semiretired commodities broker, provided his wife, Emma, and son, Vincent, with a fairly prosperous existence. Living in West Chester, Pa., the Gilpins were aware of the salubrious effects of fresh air long before Teddy Roosevelt popularized physical pursuits in the great outdoors. They were constantly off on hunting, sailing, and fishing trips — to Florida in the winter, the Adirondacks in the summer — when they weren't off touring other parts of America.

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Emma, a 42-year-old Victorian matron, and her family may have come to Florida in the late winter of 1888 partly for reasons of health. Her husband, almost 20 years her senior, suffered from chronic dyspepsia and their family physician, Dr. Rothrock, had recommended a place for them to visit: Webb's Winter Resort on Osprey at the southern end of Little Sarasota Bay. No one suspected that it would be Vincent, an only child, who would become critically ill and summon Emma's full attention and the limited medical resources available in that sparsely settled area.

Their vacation to Osprey, no more than a sand spit really, began auspiciously enough. They boarded with the Webb's in a "very nice but rough looking house," according to Emma's journal, and their first meal was "a nice supper of oysters, good bread, butter, cistern water, and figs of their (the Webb's) own raising." The Gilpin family would later believe it was a leak in this cistern, contaminating the water supply, which led to Vincent's illness, according to Vincent (Jim) Gilpin Jr.

Vincent's problems began innocently enough when an upset stomach and some vomiting on April 20, 1888, were attributed to too much lemonade, according to Emma in an explanation that mothers today might also give.

The Gilpins rested up the next day, but the following three days were filled with normal activities for Vincent: bathing in the Gulf of Mexico, sailing both alone and with his family, shooting birds, and fishing.

Then, on Tuesday April 24, while the family was out on one of the Webb's boats, Vincent became too sick to fish so Emma wrote, "he lounges in the boat until we start for the bathing place." Once there, he felt too chilled to stay in long but when the boom on their boat broke he helped to tow and row it home.

That night Emma noted that her son felt "quite

unwell." She also casually mentions "a little talk about the Yellow Fever again at Tampa" but did not seem especially concerned by it.

Vincent's bout with what the journal describes variously as dysentery or microenteritis with malarial complications began on Wednesday, April 25, and reached a turning point 14 days later on May 9. One more week elapsed before he was well enough to get out of bed, and then another week goes by until he was strong enough, after a 20-pound weight loss, to begin the boat and train trip back home on May 23.

Details about the Gilpins, Webbs, Dr. Wallace and the state of 19th century medicine were learned through interviews with Emma's grandchildren, Vincent Gilpin Jr. and Gay Gilpin Johnson; Jan Matthews, a Sarasota historian and author of *Edge of Wilderness*; Pamela Gibson, librarian at the Eaton Florida History Room of the Manatee County Central Library who is cross-indexing early issues of the *Manatee River Journal* newspaper; and Dr. Gregory Higby, acting director of the American Institute of the History of Pharmacy at the University of Wisconsin in Madison. Their expertise contributed greatly to the endnotes that follow these excerpts.

Emma's complete journal is the property of the Historical Society of Palm Beach County. Her spelling and punctuation have been kept except in cases where they might be confusing to today's readers. Paragraph indentations have been inserted for easier reading. Her entries began on April 25 when the extent of her son's illness was first revealed.

Wednesday, Apr. 25th 1888

Vincent slept well but was roused early in the morning by pain in the bowels. Lies about all morning, goes out to dinner but eats little. Has a movement of the bowels that shows signs of blood, seemingly like dysentery. At supper time, they were moved again with undoubted signs of blood — stay in bed. I staid *(sic)* with him all night, has much pain and is disturbed often through the night. He has certainly an attack of dysentery. Hoping it will soon change, I give him some of the medicines I have with me. Aconite[1] for his high fever which soon acts. This has been caused by the chill last evening on the beach after his day of feeling bad out at the mouth of the Pass.

Thursday, Apr. 26th 1888

Mr. Webb[2] says he has had a good deal to do with dysentery and has cured some serious cases. He has his old school remedies in the house and as he has been a druggist he knows how to mix them. Dr. Rothrock gave him a recent medicine book last year and I feel I must have his help and advice in this land so far away from all help in time of trouble.

How good if we were only *at home*. Poor Vincent sees visions of it constantly and wants some "house water."

Mr. Webb mixes the medicine — first blue mass and ipecac, then ipecac, camphor and opium.[3] He takes one pill every 4 hours. The opium soothes him and he sleeps in the intervals between the evacuations of the bowels. Moved very often during the night.

Mr. Webb saw him often through the afternoon — pronounced his pulse feeble and thought I ought to give him a teaspoon of brandy as he had taken no food — alarmed I do it. He has taken a few sips of condensed milk with a relish, but grows to fear it as pain always seems to succeed. His abdomen is sore. I keep hot flannel to it. Give him an enema of starch water and laudanum[4] during the night. Passages all show blood. Sleeps between every movement.

Friday, Apr. 27th 1888

The attack continues quite as bad but Mr. Webb thinks he is decidedly *no worse* this morning. Advises the use of enemas and pills. Moved nearly every hour with the pains of tenseness. The abdomen does not seem to get more sore.

In our anxiety we depend much on Mr. Webb who still continues to encourage us about the case. Assures us that it is not one of the worst cases at all, though these constant stools of blood (not very large) do look bad to us![5] May the turn come soon! He sleeps all the time between the movements — the effect of the opiate no doubt, but which the old school depends upon as one of the most important remedies.[6]. . .

We stop the enemas and the hot flannel cloths — apply a mild mustard plaster[7] — next movement has less pain. Movements nearly every hour — once or twice an interval of 2 hours. During the night a decided change in the stools, from the bloody discharge to a greenish mass a little thickened. At 2nd stool of this sort sent for Mr. Webb to see it — he sees a great improvement — stop the medicines and let the discharge continue to rid the stomach of all the material that is in it.

Pains at stool are very great each time and he feels it all now without the dulling effect of the opiates. . .

Saturday, Apr. 28th 1888

Vincent has higher fever this morning — suffers much at stool and is restless but stools still show improvement though so dark as to indicate inaction of liver. Mr. Webb thinks we should give him a dose of blue mass to carry it all off. I do so. Toward noon the stools are not full and show blood again. I give aconite for the fever and perspiration breaks out at noon — rests quietly. I put mustard plaster on abdomen until the skin is reddened — think that better than to continue the weight of hot flannels.

Dr. Wallace[8] of Sarasota was sent for today to

attend Mrs. Blackburn, a neighbor, and Mr. Webb suggested having him stop here and consult with him. Sent such a word.

Afternoon the med. acts and a great flow of dark greenish material is evacuated. Mr. Webb thinks that just the thing and he must get better. After stools return to the bloody slimy kind. Dr. Wallace arrives after sunset. Seems to be a very intelligent Scotchman.[9] Says there have been signs of micro-enteritis with the dysentery symptoms[10] — says the signs are all favorable now — that Mr. Webb gave just the right med. which he would and a dose of turpentine[11] three times daily to stop the mucus discharge — Better night than last.

Sunday, Apr. 29th 1888

W. (Webb) returned . . . thinks V. has signs of improvement — We all feel relieved though such distress remains. There are signs of *inflammation of the bowels* but temperature is slowly coming down — Yest. 101.6 Today 101.4. Pulse feeble but not so high — needs some nourishment which it is hard to make palatable for him. His constant craving is for *cool good* water and visions of *home* water are constantly before him but water is not the proper thing, they say as it is apt to increase the discharges which are now so frequent.[12] Today there is an improvement in that . . . they are fewer than yesterday.

Everyone is as kind as they can be trying to do for us anything they can but it is so strange and so hard to have him *so sick* and so far away from home and home things.[13]

Monday, Apr. 30th 1888

Last night had longer intervals of rest — was a good deal disturbed with pains of tenseness at times of stool — Awoke at 8 *bright* and refreshed saying "I feel *well* just this minute." Stools seems improved but far from natural and blood still appears. Eats a little toast in tea water — wants drink of water all the time.

Dr. Wallace comes down about noon and finds Vincent slightly improved he says— brings remedies that ought to bring about greater improvement soon he thinks — waits till 4 o'clock to note the effect of the astringent remedies.[14] Thinks he sees signs of it in the next evacuation. Leaves. After stools continue like dysentery. Had two long rests during the night.

Tuesday, May 1st 1888

Awoke at 7 — seeming better after bathing face and mouth. Stools still bad — take astringents — about 9 change a little — no appetite — thirst great and water not allowed in any great quantities and never without some acid — feels himself nervous and weak — fever pulse down and tongue better — the *signs* seem better; may they be so.

Doctor does not get here before 8 in evening — brings a quart of *sweet cow's milk*[15] which I scald and V. takes *with a relish*. Dr. thinks it will be medicine for his sore bowels as well as food. Says pulse and temperature are better— a great deal of bloody mucus is still evacuated with pains of tenseness.

Mail brought letters from Sue[16]. . . and card from Willis Hazard telling of death of Mrs. Anna Shipley. . . What sad things seem to be occurring. Wm. Jeffers writes asking us to join him and Kate on a European trip. . . How happy we would be feel if we dared think we *could* go with them. Gene writes joyously concerning Vincent's pleasures here and Aunt Sue so happily because she feels John is being so much benefited here.[17] How hard it is to feel their utter unconsciousness of all our deep trouble. I hope the milk will start the visible improvement.

Another terror stares us in the face — there is rumor of quarantining Florida from the other States on account of some cases of Yellow Fever at Plant City about 20 miles east of Tampa. It frightens me to think perhaps we will not be permitted to go North even when Vincent is well enough. . . .

Wednesday, May 2nd 1888

Vincent drank the scalded milk with so much relish that I feel much encouraged. Awakes not so bright, as he feels his ailments and confinement so much. Is so anxious to feel that he is improving that he refuses none of the various bad medicines which are prescribed. Stools still look bad and are very frequent — 7 in the last 12 hours! After washing face and mouth he ate a small piece of dry toast with half a cup of milk and did it with apparent relish — the first time since his attack.

We grope our way almost in the dark — Oh! for the light to come!

Dr. comes after dinner and finds not much improvement- his pulse and temperature decidedly higher which seems hard to be accounted for. Decides quinine is necessary to curb the fever symptoms — give it at once and add it to the other oils of opium and camphor[18] which he takes every four hours. We trust tomorrow will show greater improvement.

Thursday, May 3rd 1888

The disturbance of rectum with blood and mucus still very frequent. Slept 2 hours at a time several times through the night. Takes milk and a tablespoon of rice for breakfast. One stool this morning much more natural than any he has had before — signs of milk through it! the blessed milk! How we will keep getting it is one unsolved question-

Stools of mucus look better to me — Pulse down to 90 and temperature slowly down to 99 — sleeps in the morning. . .very quietly and comfortably. Afterward eats small piece of toast and half cup of milk.

Seems brighter.

Afternoon fever and temp higher. Dr. finds them so and pronounces his case with a malarial complication — fever intermittent- many stools of blood and mucus from the rectum — he says it is never a *serious* feature tho hard to control — leaves concentrated extract of witch hazel[19] to take inwardly instead of enema because he fears the latter will irritate the rectum. Afterward I taste the witch hazel and find it so astringent to tongue that I am afraid to give so much of it into the stomach — the latter is not yet seriously affected and it would be sad indeed to upset it.

Dr. brought a quart of milk which was *sour* when he got here! Alas that so simple and so necessary a thing should be so *hard to get* — for 24 hours he must do without milk and Dr. thinks he cannot get well without milk.[20] So many things we want and cannot get. That seems the hardest part of this heavy sorrow—

Increase the dose of quinine — Give enema of witch hazel and think is less evac. of blood thereafter although he is very frequently disturbed during the night.

Doctor is still very encouraging — Says nothing indicates an uncontrollable case — May he be right! V. talks and thinks much of home and is so anxious to be able to start as soon as (Emma's writing is unclear here.) We engaged The Vision[21] next week.

Friday, May 4th 1888

. . .Vincent woke very warm and feels the heat all morning — stools seem better. . . Give enema wh. (which) he retains nearly an hour. Less dull all morning, but not sleeping. Ate a piece of toast and a cup of tea about 9-misses the milk much — pulse 94 — temp 100.9 — Dr. brings milk. . .

Saturday, May 5th 1888

Seems no better but Dr. says there are more favorable symptoms but some complications — signs of malaria in fever every afternoon — Motions of blood from rectum are quite as frequent though somewhat changed in character, looking towards healing milk effects changes in stools — more natural — yellowish not green.

Feels the heat — We can keep the temperature of the room about 78 degrees sometimes 80 degrees for a little while. Still likes the milk. Much disturbed at night, frequent motions.

Sunday, May 6th 1888

Notwithstanding the restless nights — moved every hour with only blood and mucus discharges — the temperature, pulse and respiration are nearer the normal. Mr. Webb must go to Bradenton today, but thinks the signs are for the better this morning.

We succeed in using a bed pan this morning and that must ease him a great deal from the exhaustion and pain of getting up and down from the bed — a hope springs up that now the turn must come.

Dr. Wallace comes down about 5 to stay all night[22] —thinks the evacuations show signs of healing and finds all the symptoms more favorable. Gives some carbolic acid and glycerine[23] internally and an enema of same which was not retained long. Much disturbed all night — had very large stool of softened yellow-fecal matter wh. (which) must relieve the system much — it was followed by many evac. of rectum — On the pan quite half his time if not more.

Make arrangements with a man 7 miles up the bay to bring us milk every morning. He has it here at breakfast time but says he cannot bring it tomorrow or Tuesday. Dr. brings some with him from Sarasota but the heat has soured it.

Vincent talks about going home with the greatest longing and anxiety. Could any imprisonment be worse than such a one of fear, anxiety, and suffering as this. Oh! if we may be permitted to get to our earthly home once more all *all together!*

Monday, May 7th 1888

Dr. finds V.'s temp.-pulse-and respiration almost normal this morning and accounts for the irritation of the rectum and frequent movements from their being the consequences of the passage of so large a stool of fecal matter last night, over the tender rectum, irritating the surface afresh.

He gives enema of glycerine, witch hazel, and 3 drops of carbolic acid. It burns a great deal and V. feels it more than any application before this — He does not care for food at all — fears pain will follow every thing he swallows — is moved so frequently that we give him 1/2 gr. opium which soothes him and keeps him from evac. for two hours.

Will Webb[24] goes up for the milk this morning — a ride of 14 miles on mule back — brings it back just *turning sour.* It seems as if we could hardly be farther away from necessities than we are here but the whole family of Webbs are as kind as can be. Will proposes to go up again this afternoon for evening's milk but his baby "Charlie" is sick at his house and he has not seen him today. It is raining and threatening to be very dark — he might not be able to see the road back — so it is decided to wait until tomorrow morning and we will do with something else tonight. The shower of rain that has passed over us left a little moisture and the air is quite cooler.

Vincent is moved very often this afternoon but Dr. thinks healing of the ulcerated rectum has commenced and he will feel better soon. Temperature higher again this evening. Keeps his bed altogether now, with the aid of the bedpan.

Dr. stays all night tonight — expects to go early tomorrow morning. No *near sign* of *going home* yet!

Tuesday, May 8th 1888

Dr. leaves about 6 this morning after seeing Vincent and finding his temperature again higher though some signs are favorable. Will Webb goes up the Bay in a boat. . .for milk at Bryants — walking back 3 miles to Clowers[25] and sailing down the rest of the way. Gave him some to take down to his sick little Charlie.

Vincent seems to me better today — the discharges of blood are much less and he *seems* brighter and better and my heart feels a little lifted.

Mail brings letters from Sue, Ellie, and Julia, only Ellie had got word of V's illness up to the time of writing.

We rest more through the night though V. is disturbed quite often. He feels very warm all the time. . . He is certainly very sick yet and is growing so thin and weak. . . .

Wednesday, May 9th 1888

Dr. did not get here last evening. It rained hard and he was called early. V.'s pulse, temp are nearly normal this morning at 8.30. He takes his milk quite willingly and it must be food and drink to his famished system.

Dr. comes about 4 PM — says he is doing well, but *not very well.* The bowels (lower) are ulcerated and are now beginning to heal making them very tender when the passage of matter from the stomach occurs.

He says the point of *danger* he (Vincent) is leaving but has malarial symptoms that make it all slow and tedious. Temperature higher this afternoon again. The outlook is tedious but I am only thankful that we *may* look forward toward his recovery, no matter how far ahead it may be.

Poor suffering boy. He is so anxious to get well enough to go to our Greenwood Cottage home.[26]

Thursday, May 10th 1888

The turn for the better seems to have come today. Last night he was disturbed less often and rested better. This morning began a change and he was disturbed only at intervals of 4 hours with natural passages — a good deal of pain with each.

He craved something different from the milk and toast which he has been having and with the Dr. consent I gave him for breakfast a small piece of beef steak with some toast and he ate it like a starving person and rested long and well immediately afterward. At noon I gave him brandy and bovine and milk and John killed 2 doves for his supper — tiny things, but which he relished very much.[27]

Dr. came at 4 and found him much improved — more in the last 24 hours than in any three days preceding — Tells me what to give him to eat — Rests pretty well during the night.

Friday, May 11th 1888

V. awakes not quite so bright — has pain several times without adequate relief — feels dull. A small fish I broiled for his breakfast and he ate it with good relish. Pulse and temp. a little higher this morning. Last of day more comfortable and signs of constant improvement. Best night he had — disturbed but once between 10 PM and 7 AM. . .

Saturday, May 12th 1888

V. seems better this morning. Eats a little fish at breakfast and *sits up* for oyster broth for dinner. Bowels show better signs. Dr. comes at 4 and says much improvement visible. Thinks he can start northward soon and suggests a few days stop at Sarasota with Mrs. Jones[28] if her business difficulties do not prevent.

Sunday, May 13th 1888

Last night better — Vincent thinks he will relish breakfast — does so. Much pain at stools and signs of inflammation but they are much less frequent. . . V. enjoys chicken broth for dinner. . .feels very weak and low spirited— finds it very easy to cry.

The "Vision" at Sarasota sent man and boat down to learn our plans. Send word back to the doctor that the boat will be off and in face of Mrs. Jones' difficulties we think it best not to try to stop there on our way North. V. seems fretted at the idea of stopping anywhere else on our way home and friends here think it very risky to change water and location for him. The Florence[29] can take us up when we are ready we trust. Little Charlie is quite ill in the same way. . . .

Monday, May 14th 1888

V. stronger today — sits up awhile — appetite better — stools fewer but with pain — 4 times — a little blood.

Tuesday, May 15th 1888

V. enjoys his food — sits up longer — only drawback a little blood from straining at stool — to be expected. We all feel better.

Mail brings letters from Sue, Hettie. . .(and others.) Sue's letter the first since she heard of V.'s illness full of anxiety. Hettie's full of fear for us and *terror* at the thought of "inflammation of the bowels." I write to Sue, . . . Hettie, . . . and Dr. Wallace.

Wednesday, May 16th 1888

V. decidedly better and stronger — has good

appetite and brisk walk across the rooms. Sits in a chair several hours — Dr. W. comes about 5 — the disease is conquered now and he wants *good nursing* to restore his strength — Wants *strengthening* — He thinks *brandy, wine, iron* — Thinks he can prudently eat of nearly everything ordinarily good for him now.

I omit tar and opium[30] and he is disturbed more frequently through the night though healthfully — probably from the fruit and lemonade he used during the day.

Seemed low-spirited after Dr.'s visit. The talk of his weakness was discouraging to him.

Thursday, May 17th 1888

V. awakes rather despondent — is roused by pain in bowels — eats his breakfast with better relish than he expected and feels better. Is thinking and longing for home.

John went with Walter over to the beach and took a sea bath[31] — the first since V.'s last day out. V. walks around the rooms a little and thinks he feels stronger.

The day is very warm, with a fresh breeze outside. J. (John) does not feel so well — has been twice overheated today and suffers from that.

Friday, May 18th 1888

Last night was *the first undisturbed* night V. has had since he took his bed and he feels much stronger this morning. Eats a good breakfast and puts on his clothes for the first time and walks out to the dining room where Will weighs him and makes him 82 1/2 — a loss of over 20 pounds! No wonder he looks thin and has much to make up — Condition of bowels seems much better today. Appetite and spirits are good — being up and dressed are so cheering — He does not feel willing to go back to his bed clothes alone — Tired in the afternoon.

. . .I write to. . .Dr. Wallace. . .

Saturday, May 19th 1888

Another undisturbed night — and V. dressed for breakfast in the dining room. . . Very warm day. V. went out to all the meals today. Felt more inspirited to do so — J. not so well.

Sunday, May 20th 1888

Not a good night — disturbed several times and very restless. Awoke not so bright. Went out to breakfast and returned to rest and sleep all morning. Keep rooms all day as we all feel under the weather. A heavy storm of wind, thunder, and rain came in today. . . — plenty of cistern water — V. mending though despondent. Trust we may very soon move towards *home*.

Monday, May 21st 1888

A good and undisturbed night which is *very* good as the medicine with opium is given up now.

Tuesday, May 22nd 1888

Morning fair and the Marshes[32] do not start on their trip to Sarasota Village so we fear delay for our going. V. so much stronger that we want to make a start. Consult with Marsh who says they have no plans so John goes over to see Mr. Guiptil (sp.?) and he says he can be ready to start on Thursday morning.

Mail in with letter from Sue-Julia. . .word of V.'s getting better has reached home. I write to Sue-Ella Bush- and Dr. Wallace for his bill.

We are all relieved that a time is set for our start toward home. . .V. better; J. not so well — suffering from overheating.

Wednesday, May 23rd 1888

V. much better and J. also. Pack everything today ready to aboard this afternoon. All settled up by evening. Dr. Wallace does not come down with his bill, disappointment, because we shall be obliged to stop to pay him or send it to him — very awkward.

Thursday, May 24th 1888

Called at 5 AM to get aboard the Florence. Say goodbye to the Webbs and get aboard at 6. Start with Mr. and Mrs. Marsh at once and get breakfast aboard... V. sits up all day and is *very hungry*.

From here on, it was almost clear sailing home. The Florence arrived in Sarasota Thursday night where after paying the doctor's bill John Gilpin also got a "health certificate in case of any quarantine detention through the state." Emma noted that a case of yellow fever was reported in Bartow in addition to those in Tampa but at this point her delight at going home with a healthy Vincent made her concentrate on the present moment rather than on possible future concerns and she ends the day's entry observing that there was a "beautiful moonlight night."

Late Saturday afternoon as they passed Ballast and Catfish Points near Tampa Bay, they were stopped by a boat flying the yellow quarantine flag but after providing satisfactory answers they were allowed to sail up the Hillsboro River and disembark.

The Gilpins caught a 9 PM train on Saturday, May 26, with every expectation of arriving in Philadelphia on Monday afternoon. So well had, Vincent recovered, in fact, that Emma turned her thoughts away to notice her fellow passengers, commenting on a box of "lovely . . . exquisitely fragrant blossoms" of Cape Jessamine that the train conductor brought aboard at Jacksonville, and even anticipated attending a wedding recep-

tion for an old family friend on Monday at 5 PM. "We all feel this day's warm ride but V.'s appetite keeps up and he seems to bear it best of the party," she writes at the end of Sunday, May 27.

Unfortunately, their train arrived late so after "taking supper at the Broad St. station" they arrived at Cousin Ella's Philadelphia house between 8 and 9 "to see whether we could find a room there." They did of course. Cousin Ella and other relatives had returned from the wedding reception and they all "set down for some of the cake and cream at once." The journal ends:

"Ella is willing to give us her room and we are glad to find ourselves in homelike quarters in Philadelphia once more and all safe and sound after our great dangers and privations!"

Endnotes

1. Aconite, a derivative of the dried root of wolfsbane or monkshood, was commonly used to reduce fevers, according Dr. Gregory Higby. During the latter half of the 19th century, there was a trend toward home remedies and alternative medical therapies such as hydrotherapy or water cures. The Gilpin scrapbooks owned by Vincent Gilpin Jr. contain brochures for water-spas, so it's reasonable to assume that Emma packed medications the way mothers today travel with first-aid kits and Tylenol.
2. This probably refers to John Webb, patriarch of the Webb family, according to Jan Matthews. The Gilpins relied on John Webb's pharmaceutical knowledge acquired through running a "chemist's" shop in New York State. Webb moved his family to Osprey in the late 1860s where he farmed a homestead and eventually opened a boarding house.
3. The course of Vincent's treatment indicates that he was being treated with what was called "heroic medicine" in the 19th century. Heroic medicine was based on Galen's humoral theory of disease; namely, that the body contained four humors — blood, phlegm, yellow and black bile — and that health was the result of their proper adjustment or balance while disease resulted from their imbalance.

   The goal of heroic practice, according to Dr. Higby, when surgery wasn't considered was to cause the patient to excrete the poison, the "bad" humor, or whatever substance was instigating the illness. To this end, physicians might bleed patients, make them blister a lot, or give them strong laxatives, emetics, enemas, and diaphoretics which cause tremendous sweating.

   The medicines given here produced these effects. Blue mass was a mercury product used as a laxative but also as an alterative to alter the balance of the humors. It was thought especially to increase the excretion of black bile. Ipecac was an expectorant; in low doses it caused salivation and the elimination of phlegm; in higher doses it caused vomiting, especially of bile. Camphor was used as a restorative for general health and as a stimulant to increase respiration; and opium was given not only to relieve pain but also to stop frequent bowel evacuations.
4. Laudanum was a derivative of opium, and starch water was probably used both as an invigorant and as a soothing agent, according to Dr. Higby.
5. Throughout the journal Emma will pay much attention to the frequency, consistency, size, color, smell, etc., of her son's bowel movements as a guide to the status of his health. Pediatricians today acknowledge that mothers, particularly of young children and infants, can tell how well or ill their children are by changes in bowel movements so the seemingly excessive amount of time Emma spends describing Vincent's bowel movements are not so unusual at all.
6. Sleep, then as now, is one of nature's best curatives so some things in medicine never change.
7. When applied to the skin, mustard plasters produced a red, irritated area. This effect, it was believed, would act as a counterirritant so if Vincent's intestinal tract was irritated it would seem reasonable to apply a counterirritant to the abdomen.
8. Information about Dr. Wallace, the first and only doctor in Sarasota for many years, is sketchy at best. Neither the Florida Medical Association nor the Borland Library in Jacksonville have any record of him.

   "The first reference we have of him is on a cutline of an 1886 photo identifying members of the the Florida Mortgage and Investment Company," says Ms. Jan Matthews. This group of settlers came to be known as the "Scotch colony" since many of its members came from Scotland. According to John McCarthy of the Sarasota Historical Society, the Browning manuscript refers to Dr. Wallace's having a two-story wooden frame house with an open porch on lower Main Street where he had a home office and a drugstore. This information appears in *Yesterday's Sarasota* by Del Marth.

   This book refers to a Dr. Thomas Wallace; however, there is uncertainty over his first name since both Jan Matthews and Pamela Gibson have found reference to a Dr. Robert Wallace. Ms. Gibson has found his name mentioned many times in the *Manatee River Journal*, namely in his effort to treat cases of yellow fever which appeared in Sarasota from September 1888 (after the Gilpins had left) to January 1889.
9. It's important that Emma mentions Dr. Wallace's Scotch background because Edinburgh, Scotland, was a famous center of medicine during the early 19th century. According to Dr. Higby, Scotch instructors had tremendous influence on medical practice throughout Europe and the United States. One physician, William Cullen, who used heroic medical practices, wrote a book of therapeutics and Dr. Higby believes it's very likely that Dr. Wallace would have been familiar with this text.
10. It is difficult to diagnose past illnesses from personal written accounts. Later in the journal, Emma will mention malarial complications; her grandson, Vincent Jr., says Vincent himself thought he may have had typhoid. Dr. Higby believes it's even possible that Vincent may have just started out with a simple case of food poisoning whose symptoms were exacerbated by harsh medications.
11. An example of harsh medication, turpentine was used to clean out the bowel and eliminate any intestinal parasites.
12. Being deprived of water in combination with his physical distress may have led to his being nearly dehydrated, according to Dr. Higby. This symptomatic complication certainly would have added to the seriousness of his sickness.
13. Just as Vincent longed for home water, his mother longed for her home things: most likely, comfortable, familiar surroundings; Dr. Rothrock, her family doctor; and her support system of close friends and relatives.
14. These were probably administered to "tone up" the intestinal tract, according to Dr. Higby.
15. The fact that the doctor brought cow's milk for Vincent says something not only about the quality of his house calls but also about the unavailability of certain basic items at Osprey.
16. From entries here and in other journals, Emma is shown to be a frequent letter-writer to many friends and relatives.
17. As mentioned in the introduction, John Gilpin had his own intestinal problems and his sister, Susan Gilpin Hazard, may very well have commented about the state of his health in her letters.
18. Again, opium would have been used not just for pain but for its tendency to stop bowel evacuations. Camphor was used as a restorative for general health but also as a stimulation to increase the rate of respiration.
19. Witch hazel would have been used to restore tone to the intestinal tract, to help heal any lesions that might be there, and to stop any bleeding that may have been occurring.
20. It likely that Dr. Wallace had sailed down from Sarasota with the milk which could have spoiled because of the sun and the heat.
21. "The Vision" is the name of a boat which would have taken them to Sarasota and to Tampa where they would have caught train connections home.
22. Again, an indication of the caring quality and attention Dr. Wallace gave his house calls or else just a commentary on the state of transportation and schedules.
23. This combination would have been used primarily as an antiseptic to clean out whatever putrid material would still be in the bowel.
24. Will Webb, a builder, was John Webb's son.
25. The Clowers were, most likely, other homesteaders.
26. Greenwood Cottage was the Gilpin's summer cottage in the Brandywine section of Pennsylvania which they rented to a tenant farmer after their move to West Chester, Pa.
27. Not the diet for a recovering child today whose mother might feed chicken and chicken soup, but in their absence beefsteak, bovine, brandy and doves will have to suffice.
28. This is probably the Mrs. Annie Jones, another member of the "Scotch colony" who with her husband, Alfred, ran John Hamilton Gillespie's De Soto Hotel. It's unclear what her business difficulties are at this point, but Del Marth's *Yesterday's Sarasota* indicates that Mr. and Mrs. Jones found it difficult to get along with Gillespie's first wife and left in 1891 to open up their own hotel, the Tarpon Club.
29. "The Florence" was a sharpie sailboat.
30. "Although pine tar was used externally in America as an anti-eczematic, it's use internally was unusual," says Dr. Higby. "The internal use of pine tar was more typical of medicine as practiced in the British Isles where it was used as an antiseptic to clean out or make sweet again the intestinal system. It's use here would have showed Dr. Wallace's Scotch training."
31. John Gilpin obviously must have been just as concerned over his son's health as Emma was but it's interesting that with the exception of his mention here, an earlier reference to his shooting doves for Vincent to eat, and another reference to his contacting the railroad agent at Jacksonville about their tickets, his role during Vincent's illness goes undescribed in the journal.
32. The Marshes were a vacationing couple who had chartered "The Florence" for a cruise of Florida's west coast and had stopped off on their return to the Sarasota/Tampa area. Because of the unavailability of the "The Vision," the Gilpins were going to rely on "The Florence" — whose primary obligation was to the Marshes — to get them to Tampa where they could take a train home.

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The Medical Profession in Florida 1821-1874

E. Ashby Hammond, Ph.D.

From the beginning of the territorial period in 1821 the Florida Territory faced health crises related to the periodic visitations of deadly fevers endemic to subtropical America. Both civil and military authorities were sensitive to the necessity of protective measures against spread of the disease, and from its inception the territorial government, even in its provisional stages, relied heavily upon the advice and assistance of medical practitioners, a pattern typical of the American frontier where often the physician was one of the few educated persons at hand.

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Boards of health ● In both Pensacola and St. Augustine, ceded to the United States by Spain in the summer of 1821, yellow fever was a deadly contagion and public health measures could not be delayed. It was, therefore, only a matter of days after the transfer of these towns to the United States (Pensacola on July 7 and St. Augustine on July 10) until the establishment of provisional governments, each of which included a board of health headed by a reputable physician. The St. Augustine board, announced on July 16, consisted of Mayor Gabriel W. Perpall; William Travers, alderman; Francis P. Sanchez, merchant; the Reverend Michael Crosby, Roman Catholic priest, and Dr. Richard Murray, health officer. The Pensacola procedure was similar. On July 19, 1821, Governor Andrew Jackson issued commissions creating a temporary government for the town. At the top of the list was his long-time friend and personal physician, Dr. James C. Bronaugh, who had served with Jackson in the War of 1812 and had become assistant surgeon-general in the American Army. With obvious confidence the Governor named him resident physician and president of the board of health. For the military post at Pensacola Jackson chose as health officer Dr. John V.D. Vorhees. As was true in St. Augustine, Pensacola's Board of Health consisted of the resident physician and members of the city council.

Within a week after establishment the Pensacola Board of Health held two meetings, at the first, on July 21, with Dr. Bronaugh presiding and Dr. John Brosnaham, a native of Catskill, New York, who had settled in Pensacola late in the Second Spanish Period, in attendance. Using the power conferred by the Governor, the Board assigned unto itself the control of licensing physicians wishing to practice in Pensacola and vicinity. Applications to practice were to be submitted to the Board "and if two thirds of the members were satisfied that he (the applicant) is

qualified, and that he is of correct moral character, he shall be licensed accordingly on paying to the Secretary the sum of five dollars.'' The Board further ordained that every physician practicing in Pensacola would be subject to a fine of $300 for failure to report any case of yellow, bilious, pestilential or contagious fever under his care.

Two days later the Board of Health found itself in the somewhat awkward position, or dubious procedure, of issuing licenses to practice to two of its members, Dr. Bronaugh and Dr. Brosnaham. As the local newspaper reported the matter, ''Dr. James C. Bronaugh, President of the Board of Health, being desirous of applying for permission to practice medicine, George Bowie, Esq., was called to the chair . . .whereupon James C. Bronaugh, M.D., presented his diploma from the University of Pennsylvania, which was deemed sufficient, and was thereupon issued a license to practice medicine in the City of Pensacola. Dr. Bronaugh then resumed the chair.'' The Board then examined the credentials of Dr. Brosnaham, a prominent citizen and practitioner in Pensacola until his death in 1871, and licensed him to practice. Similarly Dr. John V.D. Vorhees, having presented his medical diploma from the University of New York, was granted a license. Some six weeks later the Board examined the application of a fourth physician, Dr. Christopher Y. Fonda, and voted its approval.

To make certain that the people of Pensacola understood the degree of authority vested in the Board, Governor Jackson on the same day, ''in order to remove all doubts respecting the power of the Board of Health,'' decreed that ''the Board of Health possess free power to regulate the practice of medicine in the city of Pensacola, and to establish rules and regulations for that purpose, and grant licenses to such persons as may be found qualified to practice.'' At the same time, Jackson approved the addition of Drs. Moses R. Elliott and Ayers P. Merrill, of the U.S. Army Post at Pensacola, to the Board of Health.

The St. Augustine newspaper was less diligent in reporting the transactions of the town's Board of Health. Although no mention was made of its licensing function, it is assumed that such a responsibility devolved upon the Board since the general ordinances of St. Augustine and Pensacola were identical. The St. Augustine Board was empowered to ''make, and from time to time to alter, such laws and regulations as they may deem necessary to ensure the health of the City.''

Only three references to the actions of the St. Augustine Board have survived. On November 23, 1821, Dr. Micah Stone, a member of the Board, was authorized to declare that the epidemic (yellow fever) was at an end, while earlier it was reported to have issued two resolutions demanding the removal of the old Spanish Hospital from the center of the city. But licensed or not, some seven or eight physicians are believed to have practiced in St. Augustine and its environs in 1821.

As important as the control of membership in the medical profession may have been, it was superseded by the acuteness of problems arising from the periodic recurrence of yellow fever and kindred ailments. Local newspapers, inclined throughout the 19th century to minimize or even to conceal the seriousness of local epidemics, provide only minimal knowledge of the onslaughts of fevers. There is sufficient evidence, however, that both St. Augustine and Pensacola were hard hit in the summer and fall of 1821. Dr. Benjamin B. Strobel of Charleston, who visited St. Augustine in 1839 to investigate the yellow fever epidemic then threatening the city, reported interviews with Dr. William H. Simmons, a native of Charleston, who was present during the 1821 epidemic. Simmons recalled St. Augustine as ''a Filthy place,'' due in some degree to the failure of the Spanish, anticipating removal to Cuba, to maintain even a semblance of police regulation. Such conditions, in combination with the heavy rains and intense heat of the late summer, accounted for the severity of the epidemic.

Boards of Health in both towns moved quickly to implement the broad powers granted them by Governor Jackson. Quarantine grounds were designated and health officers appointed. In September the Pensacola board passed a hurriedly drafted ordinance setting forth in detail the quarantine arrangement for the harbor, specifying the duties of both resident physician and health officer as well as the fines and penalties or violation of the health code. Effective immediately the health officer would meet all incoming vessels at the quarantine area to prevent, as it was stated, ''the introduction of contagious diseases into the city.'' The resident physician entered upon his tasks of visiting the sick, visiting quarantined vessels, directing the disposal of rubbish, enforcing health regulations, and reporting regularly to the Board of Health all matters which required official action.

In the following year the appointed Legislative Council of the Territory held its first session, convening on July 22, in spite of the delayed arrival of some members of the East Florida delegation.

At its first session on the following day Dr. Bronaugh was elected president of the body. Its agendum was overwhelming in that problems were in many instances unique, and guidelines did not exist. To complicate proceedings further its work was interrupted by the appearance of yellow fever which demanded a general exodus from the city. The entire Council removed to what was presumed to be a safer place, the plantation of Don Manuel Gonzalez some 16 miles north of Pensacola. The Council immediately drafted and passed an act providing ''against the introduction of contagious diseases, and for the establishment of Boards of Health in the Cities of Pensacola and St. Augustine,'' to which Governor Duval

affixed his signature on September 2, ironically the day of Dr. Bronaugh's death.

In June 1823 the Legislative Council, working in a more relaxed atmosphere, enacted a measure repealing the entire act of 1822 and replaced it with an act empowering the boards of health in both cities to pass "all quarantine laws and to make such regulations for the preservation of health of their respective cities as may seem to them good and proper." The measure also reconstituted the boards of health to consist of the aldermen and "a resident Physician, to be appointed annually by the Mayor and Aldermen on the first day of May. . . .The Resident Physician shall be *ex officio* President of the Board of Health." This act was the first to be passed by the Legislative Council at its session in 1823. It is a matter of interest, however, that, for reasons unknown, the act was vetoed by Governor Duval. It may be reasonably speculated that he was reluctant to allow the appointive power to be removed from his control. His action availed him nothing, however, in that the veto was immediately overridden by the requisite majority in the Council.

Within the next decade or so, as other towns sought charters of incorporation, the experiences of St. Augustine and Pensacola provided the basic patterns for public health and medical regulation. The charters of the inland towns did not specify the details of regulation and, for obvious reasons, did not include provisions for quarantine. In the charters of Marianna, Quincy, Chattahoochee and Newnansville, health regulation was discretionary within the town councils. On the other hand, the charters of Magnolia (Leon County), Key West, St. Joseph and St. Marks contained provisions for quarantine regulation, setting forth the duties, responsibilities and powers of councils to impose quarantines and pass ordinances for protection of the inhabitants.

Licensing ● As time passed it became increasingly apparent that the licensing of medical practitioners in the Florida Territory could not continue to rest exclusively with the boards of health of St. Augustine and Pensacola. Settlers were arriving in increasing numbers, and certain counties, especially those lying between the Suwannee and Apalachicola rivers, were experiencing notable population growth. Of these Gadsden, Leon, Jefferson, Madison and Jackson (the last of these lying west of the Apalachicola) were becoming an area of plantations and large farms, many owned by physicians or planters whose sons became physicians. Late in 1824 the Florida Legislative Council required every person desirous of practicing medicine in the Territory to file, in the office of the clerk of the county court in the county in which he intended to practice, a diploma issued by "some college or university," together with a certificate of moral character, whereupon a license would be granted.

The flexibility of certification standards, however, may be measured by the further provision that, failing to produce a diploma, the would-be practitioner could still qualify by filing with the clerk a certificate showing that he had studied physic or surgery for two years, either at a college or under the supervision of a reputable physician or surgeon. That fact having been established, any two judges of the county could at their discretion grant a license to practice. Fraudulent certification would be punished by a fine not to exceed $500.

The act of 1824 remained in force for less than four years. It was superseded on January 5, 1828, by an act conceived, it would appear, to raise certification standards and centralize controls over the medical profession. The paucity of information on the discussions leading to its enactment does not permit a safe judgment as to why the previous act was deemed inadequate. One may surmise that conscientious physicians, especially those in the Tallahassee area, feared that clerks in the several less populated counties could not be trusted to maintain acceptable standards. At any rate, the new law established a medical board for the entire Territory, charging it with the responsibility for examining all candidates-for-practice in Florida and issuing licenses to those deemed qualified. Named to the Board by the act were physicians: Richard Weightman and William E. Simmons of St. Augustine, Robert Lacy of Key West, William D. Price and Lewis Willis of Tallahassee, Malcolm Nicholson of Gadsden County, William P. Hort of Jackson County, and Christopher T. Fonda and John Brosnaham of Pensacola.

The Medical Board was to sit annually in Tallahassee, commencing its session on the second Monday in December, *with any three members constituting a quorum.* One may well question the effectiveness of controls, however, when he reads further that any applicant presenting a diploma from some "regularly established medical university within the United States, and a certificate of moral character shall, in all instances" be licensed without further examination. Equally relaxed was the provision that whenever the Board was not in session each individual member could examine an applicant and issue a license to practice, such action being subject to review at the next regular session of the Board. The cost of the license was fixed at $10. No provision was made for reimbursing members of the Board for their expenditures incurred in attending Board meetings.

An amending act of the following November (1828) changed the time of the annual meting of the Board to the third Monday in October, and added the following members: Alfred Guthrie of St. Augustine, Henry S. Waterhouse of Key West, Thomas Munroe of Tallahassee, John J. T. Wilson of Gadsden County, and John Porter Lockhart and Harris B. Crews of Jackson County, all physicians. The members previously appointed were retained.

In spite of the efforts of a few dedicated physicians

to organize a viable professional society, and notwithstanding the apparent willingness of the Legislative Council to provide the legal foundations for the much-needed public health controls and a responsible licensing system for medical practitioners, the results were minimal. One can only assume that the hardships of travel and the difficulty of communication among the scattered settlements, spread sparsely from Pensacola around the Keys and up the east coast to Fernandina, discouraged most doctors from active participation in the professional organization. Besides, there were doubtless some practitioners of dubious qualification who were reluctant to invite close professional scrutiny. Whatever the explanation the legislative act of February 10, 1831, repealing the acts of 1828 gave evidence of the failure of the efforts toward professional self-regulation, and represents to some degree a retrogression into a casual and haphazard system of health and medical regulation. The most significant portion of the Act of 1831 follows:

> *. . . any individual desirous of practicing medicine and surgery in the* ***Territory of Florida*** *shall be enabled to do so by pursuing one of the following methods. . . First he [shall] file in the office of the county court of the county in which he may intend to reside, a diploma from some medical college. . . Secondly,* or *he shall file in the office of the aforesaid, a certificate, signed by at least two practicing physicians, residing in this Territory, who shall be regular graduates of some medical college. . . Thirdly ,* or *he shall file in the office aforesaid a certificate signed by some Professor of a medical college, that they* ***(sic)*** *have attended one course of lectures in some one of the medical colleges aforesaid, and also a certificate from one of the physicians aforesaid.*

One need only recall the rash of medical colleges appearing in many parts of the United States during the decades of the 1820s and 1830s to understand the possible consequences of the Act of 1831.

Corporate organization ● Having thus terminated the life of a state medical board staffed with responsible physicians from the most populous parts of the Territory and having committed the licensing of physicians to the caprices of county clerks, or at least to the discretion of a mere couple of physicians residing any where in the Territory, the Legislative Council would take no other significant action in matters of health and medicine for the rest of the territorial period. In the meantime physicians followed the patterns of professional behavior characteristic of general practice in rural America in the 19th century. Doctor-patient relationships were highly personalizd. Most physicians were doubtless humanitarian in spirit, dedicated to the relief of suffering; it was the era of the all-night vigil at the bedside of the sick. Many physicians became the civic leaders of their communities; most became involved in the political life of their localities. Newspapers of the times frequently reported participation by physicians in party organization of their towns and counties. Many engaged in church activities, occasionally taking their turn in the pulpit. A few turned to intellectual pursuits as naturalists and popularizers of science. Some, Dr. John Gorrie of Apalachicola, for example, wrote columns of medical advice. On the other hand, there can be no doubt that others were woefully unprepared, even by the standards of the times, to practice their craft. Some were surely insensitive to the ethical restrictions imposed on the members of their profession. And yet, under the restrictive milieu created by such acts as that of 1831, little could be done to disbar the incompetent or the outright quack.

For the years 1831 to 1845, legislation on medical matters was of little importance. Occasional items dealing with such subjects as inoculation for smallpox, fees for attendance upon prisoners, protection of physicians from the attachment of their professional equipment, and the organization of army medical personnel, emerged from time to time; little more. On the other hand the medical faculties of some Florida counties and towns were mindful of their responsibility for observing ethical behavior and acceptable standards of practice. In 1833, for example, a group of Tallahassee physicians published a list of fees which they regarded as reasonable, pledging themselves to charge no fee in excess of the published rates.

Throughout these years of apparent indifference to the medical needs of the Territory there were always a few physicians who recognized the necessity for corporate organization of practitioners committed to the highest ideals of their profession: the advancement of medical science, protection of public health, decent standards of practice, and service as the advisory voice of medicine in the councils of towns and in the territorial legislature. It is difficult to determine from whence the impetus came. Census schedules and professional cards featured among the advertisements of the newspapers of the 1830s and 1850s show that many physicians were entering Florida each year. Some of them, recent graduates of medical colleges, brought high ideals and deep concerns to their medical commitment. Others had been affiliated with professional associations elsewhere and were cognizant of the benefits to be derived therefrom.

Whatever the motivations, the consequences were evident by early 1848 when a small group of physicians from Leon and neighboring counties gathered in Quincy on May 14 and 15 with the purpose of establishing a state medical society. Present were:

Gadsden County — Richard Jarrot, Jean H. Verdier, William Booth, James L. Shields and David L. White

Leon County — James S. Bond, George W. Betton, and James Henry Randolph

Jefferson County — John L. Call and B. Waller Taylor

Calhoun County — J. M. G. Hunter

Jackson County — E. D. DeGraffenreid

The Quincy *Times* of May 20, 1848, reported: "The Professors of Medicine of this State held a convention in this place on Monday and Tuesday last. The assemblage was not too large, but we think their action will have a good effect upon the profession." At the session on the 15th Dr. Booth was elected president pro tem pending the meeting of the legislature in the following December, when it was expected that a charter would be approved and a permanent medical organization would be launched. Elected as interim vice presidents were DeGraffenreid, Shields, Bond, Taylor and White, who were to serve also as a correspondence committee. As its final act the society resolved to meet in Tallahassee on the first Monday in January 1849 by which date it was assumed that the legislature would have authorized the incorporation of the society. It was expected that upon receipt of the proper invitations and on being appraised of the objectives of the group physicians from all parts of the state would be persuaded to come to Tallahassee for an auspicious launching of the organization.

As the time for the Tallahassee convention drew near the corresponding committee appealed to their colleagues by newspaper columns and personal letters. In mid-November several newspapers published the persuasive plea of Dr. White to his "professional brethren" stating the necessity for a State Medical Society. His arguments were cogent and clear:

The subscriber, one of the Vice Presidents, and of the corresponding committee, would beg leave to call the attention of his professional brethren, and urge upon them the necessity of a State Medical Society. Convinced he is of the importance of such an institution at the present moment it would tend to elevate the profession and to vast improvement in the healing art. Far removed, as we are here, from access to large libraries, and intercourse with learned, able and practical men of high standing in the profession, we are called upon from high considerations of responsibility to unite in exertions to free from the aspersions cast upon it by Charlatans and superficial men.

While it is acknowledged that European physicians do surpass, in classical education, and in variety, depth and extent of erudition, many of us — yet in acuteness of penetration and promptness of remedial resource, in the use of means that are accurately adapted to the end, in the treatment of diseases of our climate, we are perhaps not as deficient as many would suppose.

. . . A large proportion of those who toil in the profession among us are so situated as to command few of the ordinary advantages enjoyed in large and populous cities by the profession, and they are hence driven mainly upon their own resources. Our minds, not enfeebled by an undue reverence for authority of system, we are, I hope, open to the reception of new impressions and eliciting new lights. It is important that we watch, interrogate and scrutinize nature as exhibited in the morbid state. Thus did Hippocrates, Sydenham, and others whose names are immortalized in the pages of medical history.

. . . Let us therefore unite our best efforts and endeavors to introduce into the study and practice of physic that high and refined degree of reason and philosophy, without which it is so far from affording useful aid that it becomes in reality a public scourge.

. . . The uncertainty and even inutility of medicine is the favorite cant among men who enjoy robust health, among incurable patients, and among that portion of our fraternity who avail themselves of it as a shelter from the reproach of their ignorance and blunders. With all the imperfections and uncertainty, medicine can still justly claim a body of principles and doctrines eminently entitled to confidence. If we could suppose it to be otherwise, and believe it incapable of being reduced to rules and principles, it would be unlike all other arts; those who practice it would degenerate into a herd of visionaries, empirics and imposters, and instead of being protected, they ought not even be tolerated by a wise government. If it were possible, therefore, to set medicine aside as a science and an art, it would still be impossible to suppress the instinctive feelings of mankind, and of consequence a much greater number of victims would be sacrificed to the pretensions of ignorance and cupidity.

Permit me to say in conclusion, the standard of hope is planted in the citadel of death — let us, then, as a body on the first Monday in January next, in the city of Tallahassee, assemble and unite in organizing, in order to counteract the ravages of death.

(This letter bearing the signature of Dr. David L. White Sr. appeared in the Tallahassee ***Sentinel*** *of November 14, 1848.)*

The Florida General Assembly convened on November 27. On the following day the *Sentinel* of Tallahassee noted that application was being made to the legislative body requesting an act to incorporate a Medical Society for the State of Florida. The bill was drafted under the title, "An Act Relating to Practitioners of Medicine," and entrusted to Nicholas A. Long of Jackson County for presentation to the House of Representatives. It was announced on December 13

and first read by Long on the 22nd. Its second reading came on the following day. Immediately following its third and final reading on December 28, a member moved for referral to the committee of the whole for the consideration of a special amendment thereto. The motion lost by a vote of 19 to 12 with Mr. Long voting against. Without further delay the vote on the bill was requested. It went down to defeat by a margin of 18 to 12 with Long voting for the bill. Thus died the bill in the House four days prior to the convention of physicians set for January 1. If any out-of-town physicians actually arrived in Tallahassee, neither of the city's newspapers took notice of them, nor did they report the defeat of the bill.

In the absence of concrete evidence as to the reasons for the defeat of the bill, one is left to ponder the action of the House. Reports of the Quincy meeting of the previous May contain no clues as to the provisions of the proposed charter. They only emphasized the "great necessity of a State Medical Society. . . for the protection of the rights of the people." Indications are that the bill brought to the House of Representative by Long was, in fact, drafted by the members of the Quincy group, or possibly by the corresponding committee in consultation with Long. One may speculate that Long, having committed himself to support the bill, was opposed to any amendments which might reduce its effectiveness or alter its contents. Perhaps for reasons not discernible they preferred to retain the lax and permissive licensing system authorized by the Act of 1831.

Then came a surprise move in the Florida Senate, a move which may be branded as conspiratorial. On the day prior to the defeat of the bill in the House, Senator Robert J. Floyd of Gadsden County gave notice of his plan to introduce to the Senate a bill entitled "An Act to Incorporate the Florida Medical Society." Instead, on the day following the defeat of the House bill, Floyd read a bill entitled "An Act to Incorporate the Medical Board of Florida." Waiving their rules of procedure the Senate permitted immediate second and third readings of the bill, then proceeded to approve the bill by a margin of 13 to 1, with only Senator William A. Forward of St. Augustine opposed. It passed the House unanimously on January 3 and received the Governor's approval on January 6. Since no copy of the House bill has been located, it is not possible to compare the two and to determine the bases for the defeat of the House bill.

The Senate bill was in several respects unusual. Its first section includes the names of ten members of the medical profession, who, with their associates and successors, were constituted "a body corporatc, under the name and style of the Medical Board of Florida." It may be inferred that all licensed physicians practicing in the State were eligible for membership, an inference confirmed in the fifth section of the Act which states that "all licensed physicians in this State shall be entitled to admission into the said Medical Board, upon complying with the constitution and by-laws prescribing the terms of admission, unless two thirds of the whole society shall object to such admission." The employment of the word society, in this instance, appears to be of some significance. The legislature had, in fact, created a professional association and not a mere administrative board, whatever its limitations. It is of some significance that five of the physicians present at the Quincy Convention — Jarrot, DeGraffenreid, Booth, Betton and Taylor — were omitted from the list of those specifically named to the Board. If all qualified physicians were eligible for admission, how can the omissions be accounted for?

More perplexing, however, is Section Four, which empowered the "corporation" to "appoint five members of said board to examine all applicants for licenses to practice medicine" and "to perform the same duties that are required by the existing laws of the State, and who may grant licences to such applicants, and the form of such licenses shall be adopted by a majority of said board." Then followed the astonishing proviso, "That nothing herein shall prevent any physician in this State from proceeding in the *manner now directed by law for the procuring of a license to practice medicine*," an obvious reference to the Act of 1831, which was still in force. One can only conclude that, notwithstanding the creation of a medical board, association or society, authorized to examine applicants and issue licenses, any applicant so desiring could still obtain his license from any county clerk within the state. The new medical board was doomed from the day of its creation.

Adding further substance to the idea that Florida's legislature, particularly the House, was not disposed to incorporate an effective medical society was its stance in the session of 1850-51 when a Senate bill designed to bring the law of 1831 into consonance with the Medical Board Act of 1849 was approved by the Senate by a vote of 14 to 1, only to be tabled by the House after its second reading.

Having made it clear that the examination and licensing of physicians was not to be entrusted exclusively to the members of the Medical Board, the House proceeded to pass an act and a resolution, neither of which could have endeared it to the medical profession. By that act, the House voted to grant a special license to practice medicine to one George W. Andres of Benton County (later to become Hernando), a practitioner of the Thomsonian Method, a system of botanics already in disrepute among the regular physicians. Almost simultaneously both houses passed a resolution requiring the Medical Board of Florida to establish a fee bill for medical service and report the same, if practicable, to this, if not, to the next legislature. This order, which could not have been favorably received, was promptly ignored by the practitioners.

For the balance of the antebellum period the Florida Legislature displayed little interest in the medical profession, nor did the physicians themselves seriously attempt to organize a professional association. The politics of the 1850s consumed their energies. The burning issues of the prewar years divided them into hostile factions. Most Florida physicians had been in the Whig camp, but with the break-up of their party after 1852, they gradually came to embrace the cause of secession and the Confederacy. With the coming of war many found themselves in military medicine.

As for the Medical Board of 1849, there is no evidence that it ever became a viable professional society. It seems instead to have languished for lack of support and, from its inception, to have been hopelessly moribund. Infrequently the legislature dealt with minor matters such as setting rates for physicians attending prisoners, offering testimony at coroners' inquests, and tightening the laws relating to quarantine. It was not a time for progressive legislation in the areas of public health and medical education. Aside from such secondary concerns, little was accomplished. Florida must await the arrival of another group of conscientious practitioners under the leadership of such notable doctors as Abel S. Baldwin and R. P. Daniel of Jacksonville, George W. Betton and R. B. Burroughs of Leon County and T. P. McHenry of Marion County, who were instrumental in the founding of the Florida Medical Association in 1874, which marked the beginning of constructive legislation designed to improve the quality of medical practice in the state.

- Dr. Hammond, 2015 Northwest 7th Place, Gainesville 32603.

William Hughlett and Friends: Early Medicine Along the Indian River

Mary Marshall Man, M.D.

"The trip on the little steamer on the upper St. Johns was most interesting; it was a full 24-hour run. During the day the sight of alligators, plume birds and wading cattle made it interesting; at night the croaking of frogs of all sizes and ages, and the occasional bellowing of a great alligator broke the stillness. Although the vast expanse of water and reeds, interspersed here and there with islands of palmetto trees and cypress swamps, gave an impression that the country might be very malarious, yet we were told this was not the case, and the fresh breeze that seemed to come from the ocean and the good cooking on the river steamer gave us a sharp appetite and altogether the trip was enjoyable.

The Author
MARY MARSHALL MAN, M.D.
A retired dermatologist, long active in the Brevard County Medical Society, Dr. Man has served as its secretary and, since 1975, its historian.

"When we reached Lake Poinsett it seemed to us that we had about reached the end of the world. But for an engagement to stay one winter we would never have left the deck of the little steamer. Out a quarter of a mile from shore stood the little warehouse and dock. Alongside of the runway of the dock was an approach and alongside of the approach stood four or five mule teams in water up to their necks, no house in sight and nothing that measured to our 'great expectations' of Florida. Our party boarded the wagons and conveyances and headed through the water for Rockledge. The water was so deep in places that it came into the wagons and we had quite an experience getting through dry-shod. Finally through an hour or so of tugging through sand and water we reached the back of Rockledge hammock where we got our first glimpse of the great moss-draped oaks and hickories; soon we reached the top of the hill where now stands the reservoir of the Hotel Indian River and then we caught our first glimpse of a bearing Indian River orange grove, and the beautiful blue Indian River glistening in the sunshine of a clear autumn day. No transition could ever be greater, or quicker, from the forsaken appearance of Lake Poinsett and its surroundings to Rockledge 'the beautiful' in those days as no frost had at that time destroyed the tropical growth about the grounds of the Rockledge Hotel that stood on the present site of the Hotel Indian River.

"We now changed our mind about going back on the next steamer; Rockledge seemed a paradise. Very soon we strolled out in the grove. The first tree that greeted our astonished vision was a large grapefruit loaded with at least ten boxes of grapefruit. We remarked on this beautiful sight and the enormous size of 'those oranges.' Quickly our guide impressed us with our ignorance and informed us that they were not oranges but pomelos, otherwise called grapefruit, not eatable but grown chiefly for ornamentation. A

little farther up in the grove we came upon a tree loaded with 'oranges' larger still, these were shaddock, some of which would weigh ten pounds or over, grown for ornament. Then we were shown the mandarin and tangerine oranges in great abundance and the regular Indian River orange just beginning to put on its golden color. We sampled these and they were very sweet, though not ripe.

"We noticed here and there tropical fruit trees, coconut trees with leaves 15 feet long, a lime tree that must have had on it a barrel or two of perfect limes, and a citron tree that was loaded with the citron of commerce, which resembles an overgrown lemon. All of this beautiful grove of fruit surrounded a very comfortable hotel on the banks of the Indian River, amongst the magnificent moss-draped hardwood trees that at that time had not fallen to the woodman's axe. It was paradise indeed. That evening as we sat on the veranda of the hotel we heard the splashing in the water of the river in a stone's throw of where we sat. I asked what that was and was told there was a man fishing on the dock. So we went to see the fishing, and for the first time witnessed the trick of fishing with a castnet. In less than half an hour our fisherman had caught a water bucket full of fish — and this was no particular good evening for fishing. It can't be done now. Thus ended our first day on Indian River.

"Everything in those days was primitive. There was no railroad on the east coast south of Palatka. All the freight and passenger service to this country came by way of Enterprise and Salt Lake to Titusville, or by Lake Poinsett to Rockledge. Some freighting was done to Lake Worth and Miami by small outside trading vessels, but the bulk of the business and passenger service was as before stated. We had a sailboat mail service from Eau Gallie to Titusville, known as a tri-weekly service, which of course depended upon the wind, and often it was referred to as a try-weekly, that is go one week and try the next.

"The population of Brevard and Dade Counties at the time did not exceed 3,000 people. I was told that our state senator that year received in this senatorial district 150 votes; there was no contest or he might have received a few more.

"The entire crop of Indian River oranges that year did not exceed 30,000 boxes and there was practically no other crop to ship; those oranges, however, were certainly beautiful fruit, somehow we think better than we grow now.

"The city of Cocoa was not then on the map. There was then located here, we believe, three small residences and one store. The place had not been named. Some wag painted on the bottom of an upturned boat on Oleander Point the name, 'Scrub City.' We were known for a short time only as Scrub City. The legend goes that a certain lady was having some land surveyed and the surveyor seemed tired out and weary, whereupon he was called in to have some refreshment. Accepting this hospitality he sat down to eat. Amongst other nice things he was passed a cup of cocoa. Upon complimenting the hostess and inquiring what kind of drink that was, he was told 'it is cocoa.' 'Ah!' he says, 'that is a good drink, and as this town has no name we will call it 'Cocoa.' And it continues Cocoa in spite of several efforts to change the homely name. Well, what is the difference? 'A rose by any other name would smell as sweet'."[1]

Dr. William Leland Hughlett
25th President, FMA, 1900

Growing years ● Dr. Hughlett was born at Lancaster Court House, Virginia, on October 16, 1861. He was the eighth generation descendent of John Hughlett Sr. of whom the first indisputable record is a grant of 650 acres of land in return for the transportation of 13 persons on July 29, 1652. This arrangement, known as "Head Rights," was a means of increasing colonization.

John Hughlett had settled in the Northern Neck of Virginia some 50 miles, as the crow flies, north of Jamestown. On December 7, 1667, an order is recorded for a new courthouse to be built for Northumberland County in Mr. Hughlett's Indian (corn) field and that for "four a. of land where new C.H. now stands 1000 lbs. of tobacco was to be paid to 'Jno' Hughlett."[2]

Over the years a community grew up around the courthouse which became known as Lancaster Court House. Here in the ancestral homestead William's father, Aretas Mitchell Hughlett, was born on June 21,

1830. Aretas, who had a disability which made walking difficult, had become a school teacher; his pupils assembled from the surrounding plantations.

On January 6, 1861, Aretas and Elizabeth Malvina Leland were married at her home plantation in Rehboth, Virginia. Her mother, nee Elizabeth Mitchell, was related to Robert E. Lee; her father, Charles Henry Leland, was a legislator, physician and successful plantation owner.

Elizabeth and Aretas returned to the family homestead, and here William was born in the first year of the "War Between the States." Aretas' disability prevented his serving in the Confederate army so he continued to teach as long as possible. As the war continued, the Northern blockade of the eastern shore became virtually complete; one which English and French sympathizers were unable to penetrate. The Virginia trade in tobacco and cotton was ruined and inflation ran rampant; the price of a barrel of flour, for instance, rose to $1,000.[3]

Ultimately the misfortunes of the planters and their lack of funds forced Aretas to go to Maryland to teach but he returned to visit his family as often as possible.

Sometime in early 1864 Union soldiers broke into the Hughlett homestead where Elizabeth was alone with her three children, one newborn. They made a bloody mess as they beheaded all the chickens they claimed as loot. Despite heartfelt entreaties, with a curt "orders is orders, Ma'am," they made off with William's beloved pony, a gift from his grandfather Leland. This was probably the child's first encounter with callous cruelty.[4]

William's mother, Elizabeth, must have been a remarkable woman. Of the eight children she bore in 17 years, all survived to adulthood, except John who was born June 1878, and died three months later. A letter she wrote to William on the 30th anniversary of her marriage says: "God has blessed me with one of the best of husbands and seven precious children . . .When I think of the privations of your early childhood, and the struggle of your youth and early manhood, tears will start." Of her own privations and difficulties, however, she says, "Though my pathway has at times been unusually rugged, yet I would not undo my life if I could, for I believe God's loving care has guided my footsteps and my trials have been mercies in disguise."[5]

William attended the public schools which had been organized during the reconstruction. As he grew older he learned to play the fiddle and playing at dances became a source of some income for him. Another extracurricular activity was reading medical books from the library of his grandfather Leland. A sympathetic local doctor encouraged William's medical interest by sometimes inviting him to go along when he was making home visits.[4]

We have no written documentation for William's growing years except a certificate issued to him by his former employer on June 15, 1877, which states, "This is to certify that W.L. Hughlett has been in my employ for the last three years and has discharged his duties faithfully and honestly and I would conscientiously recommend him to anyone wanting a faithful and reliable clerk." This was signed, "R.O. Norris at Lively Oaks"; a small community, three miles west of Lancaster, now known as Lively.[6]

Medical education ● Richmond recovered slowly from the shattering war and reconstruction period, and it was there that William went for medical school, graduating in 1884. The school required students of medicine to have spent a year in apprenticeship with an approved physician before matriculation. It was also common practice for students to spend two years working in a reputable pharmacy before taking some of the same courses as the medical students in order to become graduates in pharmacy. It seems quite likely that William was able to support himself and at the same time gain practical experience in both kinds of apprenticeships.

The instructional year at the University of Virginia at Richmond during the early 1880s lasted for approximately six months. All students attended the same courses, and repeated these courses during their second year before graduation.[7]

While there was no hospital immediately associated with the medical college — a common lack in those days — the hospitals in Richmond were available for clinical instruction, according to the catalog. There was a very active dispensary which appears to have been well organized for student observation and instruction. Cadavers for dissection were not legally available until January 28, 1884, but before that Old Billy and his assistant, Chris Baker, sometimes accompanied by two or three medical students were known to rob potter's field at night. In surgery operations were demonstrated on cadavers and students were encouraged to attend postmortems in the city morgue, which was located in a portion of the college.

The subjects taught were in accord with the general medical knowledge of the times, and the students were fortunate to have some truly remarkable men to teach them.

Dr. James B. McCaw, Professor of Medicine, was a graduate of the University of New York who returned to Richmond. He was a founder of the Medical Society of Virginia, a medical editor, a surgeon in the Confederate Army and a practitioner of considerable reputation. He was, "A man of most distinguished presence, magnetic and successful."[8]

Dr. Robert T. Coleman, Professor of Obstetrics, was a graduate of the University of Virginia and of Jefferson Medical College in Philadelphia. He had served as Surgeon in Chief of the Stonewall Brigade during the Civil War. He was said to be, "The ablest and most efficient teacher of obstetrics that this country has ever produced." Obstetrics was not merely didactic for the second year students delivered two or

more patients under the guidance of Dr. Coleman or his associates, Drs. Tompkins and Lee.

Dr. John Spotswood Welford, Professor of Materia Medica and Therapeutics, had moved to the chair of obstetrics and then to Professor of the Diseases of Women and Children by the time Dr. Hughlett attended.

Dr. John Syng Dorsey Cullen, Professor of Surgery, also a graduate of the University of Virginia and Jefferson Medical College, had served as Medical Director of Longstreet's corps during the late war. Under his direction the students observed surgical operations and treatments of every kind at the various hospitals and dispensaries of Richmond. Students were also instructed on the cadaver "how to prepare for and perform all the operations of surgery."

"A medical student in 1879 recalls one of George Ben Johnston's first operations. Francis Deane Cunningham, a man of established reputation, lent his presence to the occasion and generously assisted in the 'elaborate' preparations necessary to insure removal of the deadly germs, which were thought to inhabit the air and from this situation to invade the open wound of the patient. Armed with an atomizer containing a solution of carbolic acid, Dr. Cunningham carefully covered the whole operating room, spraying the germ-killing solution into the air. All through the operation he continued this important feature of Listerism. Instruments were not boiled, and though the operator's hands were washed the use of antiseptics on his hands and on the skin of the patient was not thought of. Faith in the carbolic spray was supreme."[9]

Other professors of distinction who taught while Dr. Hughlett was a student were: Dr. Christopher Tompkins, Professor of Anatomy; Dr. Martin L. James, Professor of Materia Medica and Therapeutics; Dr. Henry Levy, Professor of Physiology and Pathology; and Dr. William H. Taylor, Professor of Chemistry and Pharmacy.

Clinical instruction was carried out at the almshouses and hospitals of Richmond, chief among the latter was The Retreat for the Sick, the hospital preferred by the most prestigious Richmond physicians. Dr. Hughlett graduated March 31, 1884, and was the only one in his class to receive an appointment as Resident Physician at The Retreat for the Sick.

Land of promise ● During his six months training there Dr. Hughlett met a patient whose invitation changed the course of Hughlett's life. Of this he later wrote: "In the autumn of 1884, while in the service as a young doctor in a Richmond, Virginia hospital, I was invited, and I might say engaged, by Joseph N. Wilkinson, at whose daughter I had been making eyes, to come with him to spend the winter at his hotel, the Rockledge House, being promised the medical practice of the hotel, and an introduction to the people of 'this land of promise.' This invitation was accepted but with the understanding that the contract held for only one season."[10]

As we have previously seen after a somewhat tedious trip he arrived at Rockledge House just two days before his 23rd birthday. His practice began the day after his arrival, a Negro with an aching tooth, which he promptly extracted. Soon thereafter he was called to see the newly elected state senator from the district, H.S. Williams. He found the senator opening oysters and a very interesting person although very discouraging about the outlook for the young doctor. Williams noted there were already two good doctors in the neighborhood and that "no one got sick."

A few days later Dr. Hughlett got a "hurry up call" to see the proprietor of the Delmonico Hotel in the settlement now called Cocoa. He was allegedly suffering from a congestive chill. The choice of routes was either two miles by the sandy ridge road or one and a half miles by the path along the river. The doctor recounts that he took the path, found the patient and "looked at him long and wisely, decided that he did not have a chill but a nervous disorder; fixed him up, and that he was soon well and became a good friend and supporter."[10]

On Sunday night, October 26, 1884, flames suddenly appeared under the store next to the Rockledge House. A strong southeast wind fanned the fire which rapidly spread throughout the dry wooden buildings, totally consuming the hotel, and most of its contents and the possessions of the residents, within the hour. Undaunted, the Wilkinson family and the new doctor move into the remaining orange packing house. Despite the lack of fire insurance, the building of a new hotel was promptly started by Mr. Wilkinson.[11]

However Mr. Wilkinson's frailty must have been adversely affected by the stress of the fire and the loss of the hotel for he died the following December. During his last illness, Drs. C.A. Hentz, W.P. Moon and G.W. Holmes assisted Dr. Hughlett in his care.

The young doctor's background of firm faith, achievement against adversity and sensitivity to the needs of people made him capable of helping Mrs. Wilkinson and Nannie in many ways throughout this difficult period. However, he could not contribute the practical advice learned by business experience that Mrs. Wilkinson sorely needed. Nor could his ardor sway Nannie to marry him until the hotel was completed, furnished, and ready for an elegant, though quiet wedding.

On Wednesday afternoon, February 10, 1886, Nannie Wilkinson and William Leland Hughlett were married by the Reverend R. Weir of the Methodist Church. The bride, just under five feet, with dark hair and eyes, wore a garnet-red velvet gown, fashioned with a tightly buttoned bodice, over the front of which fell a white cascade of Brussels lace to her tiny waist. The full velvet skirt was gathered at the back into a bustle, and ruby-like sequins sewn around the neck and wrists glinted with every movement. This gown

had been custom-made by B. Altman in New York. Her daughter, Allie, says the price had been reduced from $110 to $100, "because less material than usual was needed." The groom, slender and just under six feet tall, sported a neatly trimmed Van Dyke beard and "was dressed in conventional black."

Their honeymoon trip was to Jacksonville and back, mostly by boat. For this Nannie changed into a green satin gown with a cut velvet panel down the front, a bustle behind and white ruching at the neck and sleeves. With this she wore a matching small satin hat, lined with pink georgette. The crown of the hat was covered with three dyed-to-match ostrich plumes. Her only jewelry was a watch and chain. She carried a green parasol edged with lace.[12] From the time of her marriage Nannie always called her husband "Doctor" or "Doctor Hughlett"; the facile use of first names was not customary in 1886 or for many years thereafter.

The Hughlett home in Cocoa.

The Indian River Drug Co.
(Courtesy of Fla. State Archives)

On return from their brief wedding trip, the young couple moved into quarters in the hotel. The doctor's office and a pharmacy were built near the river. On the spacious grounds around the hotel the doctor had a cottage built for his bride and himself.[13] Here one year later, on February 5, 1887, their first child, Harriet Elizabeth, was born. Dr. Charles A. Hentz of nearby City Point served as Nannie's attending physician.

The year 1889 brought unforeseen changes in the life of Dr. Hughlett. The widow, Mrs. Wilkinson, was persuaded to build a laundry in connection with her hotel, increasing her mortgage to do so. Neither she nor the doctor were sophisticated in business affairs, and when the hotel income proved insufficient for the mortgage charges, all was lost to the unscrupulous businessman who had advocated the over-expansion. Unfortunately there was no separate deed for the doctor's cottage, so that went as well.

In the four and one-half years since the doctor's arrival, Cocoa had been growing, as had his practice. Cocoa seemed a more promising place for his home and office. Accordingly he bought three lots at the corner of Delannoy and Church Streets and began construction of a small two-story home and of an adjacent pharmacy and office.[13]

The first phase of construction was completed in 1890. Dr. Hughlett's Indian River Drug Company had a pharmacy on the ground floor. There were two offices on the second floor and a balcony on the street side which shaded the pharmacy entrance. In 1901 the house was enlarged by adding several rooms and a semicircular tower, the latter at Nannie's special request. Initially the building was painted orange with a while trim and was called "Orange Manor." Later it was painted white and remained so thereafter. In 1904, in order to provide more garden space around the home and more privacy for the doctor's patients, the office and pharmacy building was moved a short way north on Delannoy. This move was accomplished by mules turning a rotary winch.

Other doctors • There were other doctors in Brevard County when Dr. Hughlett settled there. In Titusville Dr. Benjamin Rush Wilson had been established for a good many years. The son of a physician, he was born in Gainstown, Alabama, March 27, 1838. While he was in medical school the Civil War began and he left school before graduating to serve in the Confederate Army. After the war he returned to practice with his father in Gainstown. However tuberculosis developed and with his wife, Maria Jones Wilson, he moved to Florida seeking a more salubrious climate. He arrived in LaGrange, a community just north of Titusville, in 1866 and was buried there July 19, 1913. He intended to just operate a sawmill but his health improved and as he was repeatedly sought for medical advice, he obtained his Florida medical license (1872) and sold the sawmill. He established his home and office in Titusville. He is described as a tall, vigorous man with a long flowing beard. His hallmark was a gold-headed cane which he carried on his rounds. In addition to a very active

Dr. Benjamin Rush Wilson

Dr. George Washington Holmes

medical practice, he served the community as a judge during his early years, mayor of Titusville for ten years, author of the city charter, first president of the Brevard County Medical Society (1903) and a founder member of the Eastern Star and the Episcopal Church. His overriding passion was clean water and largely due to his hard work and dedication a citywide water supply was brought into Titusville.[14]

Another physician in the area when Dr. Hughlett arrived was George Washington Holmes who had a house and office along the Indian River about halfway between Titusville and Rockledge. Dr. Holmes was born November 5, 1843, in Newark, New Jersey. In his youth the family moved to Ohio. He enlisted in the Union Army during the Civil War first as a foot soldier and later as a hospital steward. Like most of the local pioneers he had an orange grove but unlike many of them, he knew a lot about medicinal plants. He had attended medical school at the Eclectic Medical Institute of Ohio and had a wide knowledge of herbs. Indeed, he was a frequent correspondent of the American Eclectic Materia Medica Association.[15] Dr. Holmes first settled at LaGrange in 1874, personally took the census of Brevard County in 1880, and was a founder member of the Brevard County Medical Society.

In those days all of the Brevard County physicians made house calls, sometimes under very difficult circumstances. They traveled on foot, on horseback, by sailboat, and by horse and buggy or horse and wagon. After the railroad came through they often hitched a ride on whatever was available, passenger car, freight car or even the handcar used by the work crews. If the distance was great and the patient very ill, they might spend the night or several days and nights to make sure the patient got well.

The story is told of Dr. Holmes' delivery of one of the Porcher babies on Merritt Island, almost due east of Dr. Holmes' office and home. A bed sheet hung on the edge of the opposite shore was a prearranged signal of the onset of labor. Having hung out the sheet the expectant father set out in his sailboat to get the doctor. On the return trip, the wind died and they were becalmed. The river is quite shallow at this point so by poling and paddling furiously they managed to get to the mother in the nick of time.[16]

Dr. Holmes was an avid fisherman and in his later years became interested in the early history of the area. He did some archeological digging but we have no record of his findings. He was in active practice in late October 1926, and died December 23rd of that year. He is buried in the cemetery of the Georgiana Methodist Church.

An early physician who spent the winters in the

Indian River area at that time and who helped the local doctors when called upon was William Parkingson Moon. He was born in Schenectady, New York, September 24, 1825. He graduated from the Philadelphia Medical College in 1859, practiced in Philadelphia and wrote a number of articles "relating to surgical operations." During the Civil War he served as a medical officer in a Union hospital. He bought an orange grove in the Indian River area and spent his winters there.[17]

Another colleague of Dr. Hughlett was Dr. Charles Arnold Hentz who arrived at City Point in September 1881. Dr. Hentz was born May 28, 1827, at Chapel Hill, North Carolina. His father was Professor of Foreign Languages at the University of North Carolina and his mother was a distinguished literary figure. During his first 18 years the family moved five times as his father taught in various "female academies" in Kentucky, Ohio and Alabama. In the spring of 1846, young Charles began reading medicine with Dr. Searcy of Tuscaloosa, Alabama. That fall he matriculated at the College of Medicine, Louisville, Kentucky, and received a medical degree in 1847. He practiced a year at Fort Jackson, Florida, two years in Cincinnati, Ohio, three years at Ocheesee, Florida, (Calhoun County), then in Marianna. When his father died in Quincy, he moved his family there and practiced from May 1856, to September 29, 1881. In the fall of 1880 he "met some men in a blacksmith's shop who gave glowing accounts of the Indian River country." He visited the area, bought property at City Point and moved his family there. In January 1882, while struggling to secure his sailboat against a heavy wind painful, labored breathing developed which he diagnosed as due to a cardiac problem. He continued his busy medical practice until May 1888, when, because of failing health, he returned to Quincy. Thereafter he visited the Indian River country a few weeks each winter until his death, June 30, 1894.[18]

Dr. Hentz, somewhat like his mother, was a prolific writer. He has left us obstetrical records, a medical diary and a two volume autobiography. Items from his medical diary give us a glimpse of the practice of medicine in the Indian River area during the late 1800s. For example on July 17, 1882, Dr. Hentz notes that a Mr. Sanders, while fishing in the Indian River, got a stingray barb behind his Achilles tendon. Because of infection his leg had to be amputated. On December 6, 1883, Dr. Hentz accompanied Dr. Holmes to see young Mr. Knight who had tetanus following a gunshot wound. Dr. Hentz attributed the young man's survival to "gelsamine" (gelsemium) prescribed for muscle spasms. In May 1884, Drs. Hentz and Holmes went together to see the elderly Mr. Wilkinson (later to be the father-in-law of Dr. Hughlett) about nonpayment of his medical bills. They had each visited him many times, catheterizing him as necessary because of urinary retention due to prostatic hypertrophy. Mr. Wilkinson, previously described by Dr. Hentz as a heavy drinker, flew into a rage and refused to pay more than a paltry fee. Dr. Hentz left in disgust but Dr. Holmes remained to calm the patient. Neither received much monetary reward for their faithful services.

At one time Mr. Wilkinson was taken with severe dysentery. Drs. Holmes, Hentz and Moon consulted and prescribed but with such little success that he despaired of his life and ordered a coffin sent from Jacksonville. Unaccountably Mr. Wilkinson began to improve and decided to go to The Retreat for the Sick in Richmond for further care. It was here that he met the young Dr. Hughlett. Having decided he was going to live, the old man told his family to send the coffin back to Jacksonville but not on the same boat he was scheduled to travel on.

In late 1885, Dr. Hentz was called to see Captain Burnham, keeper of the Cape Canaveral light. He sailed south on the Indian River to Honeymoon Lake. There he moored his vessel and walked two miles across Merritt Island to the bank of the Banana River. There he was met by the captain's son-in-law who sailed him up the river. About one in the morning they moored the vessel, disembarked and spent the remainder of the night in a "comfortable building." After daybreak, Mr. Burnham's grandson took the doctor in a cart to the lighthouse. Dr. Hentz describes passing through neglected orange groves, scrub palmetto, patches of sugar cane and fields of Egyptian pineapples. Although we know nothing about the diagnosis and treatment of Captain Burnham, Dr. Hentz does tell us that on the previous day a lighthouse tender had brought kerosene as fuel for the light, for the first time replacing the customary whale oil.

On January 21, 1886, Dr. Moon amputated a man's arm at the shoulder because of a gunshot wound that had shattered the humerus. Drs. Holmes and Hentz assisted in the operation. No mention is made of the anesthetic or the operative details, unfortunately. On February 5, 1887, Dr. Hughlett sent a hack for Dr. Hentz so that he might attend Nannie Hughlett during her first labor. Dr. Hentz spent the day and about ten that night delivered a healthy baby girl.[18]

A close friend of Dr. Hughlett and the man who shared office space with him was a dentist, Dr. Leonidas Thomas Enoch Daniel. Dr. Daniel was born near Midway, Georgia, attended the Dental Department of Vanderbilt University, Nashville, and came to Cocoa in January 1887. Dr. Hughlett and Dr. Daniel were mutually helpful, Dr. Hughlett extracting teeth when Dr. Daniel was out of town and Dr. Daniel doing minor surgery in Dr. Hughlett's absence or assisting Dr. Hughlett with surgery. Once when Dr. Hughlett suffered a partially avulsed ear in a bicycle accident, Dr. Daniel sewed it back and it healed with scarcely a scar. Dr. Daniel had a sailboat on which he sailed up and down the River carrying his foot-operated

Dr. and Mrs. Leonidas Thomas Enoch Daniel
(Courtesy of Florida State Archives)

Dr. Hughlett and his "around town" vehicle.

dental drill and a stool for the patient to sit upon so that he could administer dental care to the residents of the area on the boat, the river bank or in their homes.

Perhaps the earliest physician of the Indian River country was Dr. Moses Holbrook. Dr. Holbrook of South Carolina joined a colony of "about forty heads of families from Alabama, Georgia, Florida and South Carolina" who took up land under the Armed Occupation Act. Under a law passed in August 1842, the government would give to any head of family or single man over age 18, 160 acres of land south of Gainesville and not on the seacoast or within two miles of a fort. This was on the condition that he would erect a habitable building, cultivate five acres and live on the land at least five years.[19] Dr. Holbrook, described as "an aged man of powerful build, who brought with him his valuable library" settled just south of Captain Burnham. He administered medical care to the colonists until his death about 1845.[20]

Other early doctors of the area were Dr. John Whitfield who established a sanitarium on Honeymoon Lake, Merritt Island; Dr. Charlotte M. Norton of Lotus who also operated a sanitarium near the southeast end of the present Hubert Humphrey bridge; Dr. Thomas Chambers who developed tuberculosis, went into law and real estate and finally moved to Miami in 1909; and Dr. S.O. Scofield who came to practice in Cocoa in 1889.

Fees and humor ● The fees charged by Dr. Hughlett and his colleagues would gladden the hearts of today's Medicare administrators. We have examples of these in an account book kept by Dr. Hughlett for the years 1888 and 1889.[21] On January 1, 1888, Dr. Hughlett records treatment of Thomas E. Hardee for gunshot wounds with three subsequent office visits, total charge $8. That week he lanced an abscess and extracted a tooth, total charge $2. In mid-January he notes obstetrical fees, $25 for total care.

In mid-February he saw 18 patients in a single week, seven of these were guests at the Hotel Indian River. He records a lady from Boston seen in her room for a cough and cold, charge $1.50; a lady from Chicago seen at the hotel for biliousness, charge $2; a woman from Mims (some 20 miles north of Rockledge) with uremic poisoning, charge $5. At the end of February his book records total fees of $145 most of which he had collected. It seems that his usual fee for tooth extraction was 50 cents but if the patient could pay more he charged a dollar. Office visits were usually $1.50 to $2.50, but if they took longer or the patient was able to pay more they might be as much as $10. His obstetrical fee was $25 but in one miscarriage he charged only $20. For seeing a lady with carcinoma of the cervix he charged $13. For treating gonorrhea he charged $10 and for a catheterization using cocaine,

$1.50. On May 12 he charged Charles Hammond of Cocoa $1.50 for treatment of sexual debility; he doesn't tell us what the treatment was.

Dr. Hughlett had a sense of humor as is illustrated in a newspaper article written by him.

"On last Friday while a worthy colored citizen of this county was 'apologizing' to his wife over the weekly stipend (the wife needing the money for a new dress and the husband for taxes) the same 'blood on the moon' that has made so much trouble in the world badly influenced this pair. Whoever started the row, the deponent saith not — but at a certain stage of the game the husband, instead of kissing his wife, proceeded with his incisor teeth to take a piece of flesh from one cheek, and before she could turn the other, took a bite on some other portion of her anatomy. This so enraged the wife that she, for purposes of self-protection, seized and possessed herself of a bottle — possibly a beer bottle, and with said bottle she attempted to brain the husband, and brought the bottle in violent contact with his cranium. The forehead of his cranium being unyielding, the bottle was smashed, however, an ugly contused wound was produced. Using the broken bottle as a razor she then proceeded to work on the body of her lord and master. The job was quickly finished, and when the head of the house appeared at the doctor's office he was quite dilapidated. Careful examination revealed — head cut and contused, face scratched, clothing cut through in half a dozen places, lacerated wounds in the pectoralis major muscles and in side almost down to serratus magnus; penetrating wound of the right wrist injuring flexor tendons of forearm, much innocent blood shed. Antiseptics, plasters and bandages were brought to bear and patient made fairly comfortable. The patient, realizing that death was not soon to close the scene became loquacious and reflective. In all honesty said he — 'Doctor, you will have to charge all dis treatment, hits gwine to take all dis week's money to get out of mayor's court. I ought to have tooken your advice when you told me long ago not to git married no more.' Such is life, and the doctor can wait for his fee."[22]

On September 12, 1891, in the little bedroom with a small balcony outside and a peaked roof, a daughter was born to Nannie and Dr. Hughlett. She was christened Anna Alabama, but soon became known as "Allie", the name she vastly preferred. She later married James B. LaRoche.

Earlier we have mentioned how the doctors got around before the days of automobiles and paved highways but left untold is the story of "Indian River's Most Famous Horse." In 1894, Dr. Hughlett purchased a ten year old Kentucky horse. In the subsequent years "Old Charley" carried the doctor over 40,000 miles and became the best loved horse in the Indian River country. Then came the big freeze of December 1894, followed by a second freeze in February 1895, and the citrus crop was wiped out and the groves destroyed. For the next four years money was as scarce as hen's teeth along the River. The doctor was busy as usual but he often did not get paid. In order to raise a little cash in addition to the fees paid by winter visitors, Dr. Hughlett sent his trusted black, Waller Speed, driving Charlie hitched to the surrey, to take these same winter visitors for a paid tour of the area. This became a very popular pastime. One night, after Charlie had made five such 20-mile trips, Dr. Hughlett received an emergency call from a family living four miles west of Eau Gallie. A little girl had fallen into a bed of coals at Bovine Ridge. The doctor set out, riding Charlie over the long miles of deeply sandy roads. After examining the child, he knew that he was facing another tragic case where all that he could do was to stay and try to ease the pain of the dying child and console the parents. Much later Charlie brought his master home, the horse tired out, the doctor exhausted and disconsolate.[23]

Politics ● On October 1, 1895, a meeting was called at Wooten's store to incorporate the town of Cocoa. Dr. Hughlett was elected Mayor by a large majority of the votes.[24] He served until 1898 when he persuaded his close friend, Albert Taylor, to run for election. Although he was elected, Mr. Taylor found politics distasteful and served only one year. Dr. Hughlett was again elected and served as Mayor continuously until 1915.

Dr. Hughlett was not only personally meticulous but believed that others should be also. His office as Mayor brought with it the duties of being the Municipal Judge, investigating infractions of town ordinances and imposing penalties and fines as necessary. Keeping the streets clean and clear was evidently as difficult then as it is now. In 1915 efforts by some of the aldermen to discredit Dr. Hughlett culminated in their reversal of a fine which had been imposed on one of their cronies for constantly leaving one of his wagons on the street, forbidden by ordinance. At a meeting on December 15, 1915, one J.M. Sanders filling the chair, this letter from Dr. Hughlett was read: "Gentlemen: Finding myself at variance with the Council in the matter of enforcing the ordinances created for public safety, and particularly reversed in the matter of imposing a fine, without so much as having extended me the courtesy of a hearing, and being opposed to the adoption of an electric light ordinance and franchise passed at your meeting of the 14th instance, I hereby tender my resignation as Mayor of this city, the same to take effect at once. Yours very respectfully, W.L. Hughlett."[25]

Dr. Hughlett's life as a public servant to Cocoa had ended but he was promptly on to bigger things. In 1915, the state senator from the 13th district, F.M. Hudson of Miami, resigned to run for governor. Thereupon Dr. Hughlett began to seriously consider campaigning for that office. In an article in the *Cocoa*

News and Star, April 17, 1916, he wrote: "With a political bee buzzing in my new hat and the attraction of a little 'wee' grandson at Key West, I left Cocoa a week ago Saturday for a few days outing down through the counties of this Senatorial District. The experience of riding on a railroad train on the high sea — out of sight of land as we looked through either side of the car — is something to remember. We thought as we studied and admired this great work of human hands what might be accomplished in the Everglades of Florida if money and brains like that commanded by Mr. Flagler could be applied to the great drainage problem now confronting the state."

Further in the same article he wrote: "Our people in Cocoa and vicinity should get together. We should boost the Dixie Highway, build the high school, bridge the Indian River, bridge the Banana River to the ocean at Canaveral, beautify the city and cut out every evil thing that is within our gates."[26]

His campaign platform as summarized in the *Miami Metropolis* was: "Statewide compulsory education, the bestowal of suffrage rights upon the women of Florida, the abolition of the liquor traffic, the reformation of the land-title system, a modification of the fee system, a measure for making the East Coast canal company abide by its contract, an Everglades commission through which the reclamationof the 'Glades can be secured in a scientific, business-like way. . ." In addition to these items he vigorously supported legislation to abolish child labor, favored medical inspection of school children and clear separation of the church and state. His platform ended with: "Let us see to it that the ideals of Washington and Jefferson do not perish from the earth!"

Enthusiastically endorsed by the *Palm Beach Post*, *Melbourne Times*, *Miami Metropolis* and *East Coast Advocate*, Dr. Hughlett easily won the election for senator of the 13th district: Dade, Broward, Palm Beach, St. Lucie and Brevard Counties.

Dr. Hughlett served in the regular Senate sessions of 1917 and 1919, and the extraordinary session of 1918. His performance in the Senate is difficult to assess because the Senate journals of that period are poorly indexed however he seems to have been an active legislator. As relates to medicine he attempted to bring the practice of surgery under the control of the State Medical Board but his bill was tabled. He managed to get a bill through to accept federal funds to control the spread of venereal diseases and a bill requiring nurses and midwives to report cases of eye infections. He introduced legislation for women's suffrage but it was defeated. Recall that it was not until 1969 that Florida ratified the 19th Amendment passed by the U.S. Congress in 1919.

Organized medicine ● From his early years in practice and throughout his life Dr. Hughlett was active in organized medicine. For example when in November 1893, Dr. S.G. Worley, Chief Surgeon of the Jacksonville, St. Augustine and Indian River Railroad (immediate predecessor of the Florida East Coast Railroad) called a meeting to organize an association of railway surgeons, Dr. Hughlett was present. This became the East Coast Line Surgical Association which later became a statewide association. At one point Dr. Hughlett became president of this organization.

Active in the Florida Medical Association from the beginning of his practice, Dr. Hughlett was elected second Vice President in 1898, first Vice President in 1899, and President in 1900. At the annual meeting in Orlando. April 11 and 12, he presented a paper on tuberculosis emphasizing its contagiousness and its spread by droplets.[27] A recommendation was sent to the State Legislature that spitting in public be made unlawful and punishable by a fine but it is said the recommendation was laughed down. After his year as President, Dr. Hughlett continued to serve the state society in various ways. He rarely missed the Annual Meeting, served on various committees and was Councilor for the Seventh District for a number of years. At the Annual Meeting of 1904, Dr. Hughlett offered a resolution: "That the House of Delegates of the Florida Medical Association assembled, condemn the action of the last session of the Legislature imposing a license fee on physicians, as inimical to the best interests of the State, and without warrant of law, and that this resolution be referred to the Committee for Public Policy on Legislation to use their best offices and endeavors to secure the repeal of said statute." This passed the House of Delegates unanimously but got no where in the Legislature.

On October 15, 1903, a group of physicians met in Brevard County to form a medical society. The initial officers were Drs. Benjamin Rush Wilson, president, George Washington Holmes, vice president, and William Leland Hughlett, secretary-treasurer. Throughout the years Dr. Hughlett was a stimulating force in the local society and in 1914 was elected president.

Along with his busy practice, community responsibilities and services to organized medicine he attempted to keep up with scientific advances in medicine. He made it a practice of taking a month off in August when, after visiting his parents, he studied by observing at clinics, mostly at Johns Hopkins and Mayos. One year he took his family to New York with him so that he could study optical refraction at Polyclinic Hospital, there being no one in Brevard County with this skill. His only summer trip purely for pleasure was to the Grand Canyon in a private railroad car owned by a wealthy winter visitor. He encouraged local physicians to present papers at the local and state society meetings and contributed his own. His paper on tuberculosis, first presented in 1900, was reprinted in the Transactions of the F.M.A. of 1905. Also that year he gave a paper challenging the current practice of pushing food in cases of typhoid fever. Recall that the cause of typhoid was known but no specific treatment was

available. Based upon his observations and reading he advocated: "Clear the bowels first with calomel and soda, and if necessary afterward a gentle purge occasionally with castor oil and small doses of spirits of turpentine. Give them plenty of water to drink, also lemonade and fruit juices, a small quantity of liquid food if they desire anything, otherwise no food for the first two or three weeks. The temperatures, if very high, may be controlled by cold baths or, what I much prefer, frequent sponge baths. I doubt the value of any systematized treatment with drugs."[28]

His last contribution to the medical literature is an article on hypertension that appeared in the August 1923 issue of the Journal of the Florida Medical Association. At the outset he tells us he will give us the "findings of other and more able observers." He reviews the theories of etiology then current, mentions the complications of hypertension, divides the disease into three classes based on symptoms and clinical findings and then discusses his treatments. Curiously he notes that some of the patients he saw were on a salt-free diet but he found they did better if allowed "a little salt." After mentioning a number of drugs and modalities of treatment he settles on acetphenetidin or phenacetin if the blood pressure exceeds 200. If the heart is rapid and pulse bounding, he used aconite, digitalis and bromide of soda. If the kidneys were flagging, he prescribed acetate of potash with extract of squill; if albuminuria was present he used iron oxide with bitartrate of potassium. To prevent hypertension he recommended, "temperance in all things," a guiding principle of his life.[29]

An assistant ● In 1924 Dr. Hughlett, now 64, invited his nephew, William Smith Hughlett, to become his assistant. Young William, a recent graduate of Emory College and Medical School, was soon able to take over some of the burden of his uncle's practice. In 1925, when Dr. Hughlett became very ill with acute obstructive cholecystitis, young William called all available consultants, as requested by his uncle. The consensus was that surgery must be performed and accordingly the patient was transported to the nearest hospital which was in Orlando. Unfortunately at that time it was a long journey over deeply sandy roads, and by the time he arrived, peritonitis had set in and he did not survive in those preantibiotic days. He died September 19, 1925.

Thus ended the life of one of Florida's most distinguished physicians, a life dedicated to the welfare of others. He was a man of integrity and wise counsel and a fine and compassionate physician.

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References

1. Hughlett, W.L., "Thirty Years Ago and Now," *Cocoa News and Star*, October 16, 1914
2. Genealogical research by the late F. Hughlett LaRoche recorded on a tape.
3. Various sources including Hugh McCulloch, Men and Measures of Half a Century, Charles Scribner's Sons, 1888, and Charles and Mary Beard and son, William, Beard's Basic History of the United States, Garden City, Doubleday & Co., 1960.
4. Remembrances of the late Anna Alabama (Allie) Hughlett LaRoche recorded on tape
5. Letter. Elizabeth Leland Hughlett to her eldest son, William, January 6, 1891
6. Certificate of Employment by R.O. Norris of Lively Oaks, Virginia, (Not stated is that the wage was $50 per annum) June 15, 1877
7. Catalogue Announcements, Medical College of Virginia, 1883-1884.
8. Archives, Medical College of Virginia, and Blanton, W. B.: Medicine in Virginia in the Nineteenth Century, Richmond, Garrett & Massie, Inc., 1933.
9. Blanton, W.B.: Medicine in Virginia in the Nineteenth Century, Richmond, Garrett & Massie, Inc., 1933, p.148
10. W.L. Hughlett, "First Impression of Florida Changed Quickly to Another More Favorable," Miami Herald, 1914.
11. "By the Flames," Indian River Sun, October 27, 1884
12. Oral and written family history and "Betrothment Fulfilled," an undated newspaper article.
13. List of land acquisitions by William L. Hughlett from the Brevard County records.
14. Information from Mrs. Ethel Battle of Titusville, Dr. Wilson's daughter.
15. The Medicinal Plants of North America, Revised from the Transactions of the American Eclectic Materia Medica Association, edited by Arthur Weir Smith, A.M., M.D., Vol. 1, Berwyn, Ill., 1914
16. Porcher family oral history.
17. Information obtained from Colgate University.
18. Diary of Dr. C.A. Hentz. This and other items left by Dr. Hentz are to be found in the Southern Historical Collection, University of North Carolina, Chapel Hill
19. Tebeau, Charlton W.: A History of Florida, Coral Gables, University of Miami Press, 1971, p.149.
20. Hanson, Robert: A Memoir of Captain Mills Olcott Burnham, A Florida Pioneer, Written For Members of His Family, St. Augustine, Florida, 1926.
21. Hughlett, W.L.: Visiting List with Special Memoranda, 1888 and 1889.
22. From a newspaper clipping which is undated and doesn't include the name of the newspaper.
23. Dobson, W.B., "The Indian River's Most Famous Horse," unidentified newspaper clipping, about May 10, 1916.
24. Minutes of the meeting for incorporation of the town of Cocoa, October 1, 1895. Photocopy provided by Chas. W. Skelly.
25. Minutes of the meeting of the town and city of Cocoa, Cocoa City Hall, December 15, 1915
26. Hughlett, W.L., "The Land of Promise From Cocoa to Miami," Cocoa News Star, April 17, 1916.
27. Hughlett, W.L.: Human Tuberculosis with Especial Reference to Pulmonary Consumption — The Great White Plague, Transactions of the F.M.A., pp. 71-84, 1900.
28. Hughlett, W.L.: Feeding in Typhoid Fever, Transactions of the F.M.A., April 19, 1905, pp. 57-64
29. Hughlett, W.L.: Cardio-Vascular Troubles and Some Suggestions As To Treatment and Prevention, J.F.M.A. X: 44-49, August, 1923.

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The Summer Nightmare: Poliomyelitis in Florida

Kathleen Hardee Arsenault

Poliomyelitis, like plague in the Middle Ages and tuberculosis in the Romantic period, will perhaps share with AIDS an indelible place in the 20th century's history and folklore. For Florida's participants in annual March of Dimes fund drives, its volunteers who tested Salk and Lederle vaccines, and most of all for the survivors of the devastating epidemics in the 1940s and 1950s, the disease remains a vivid memory.

Although polio seems to have existed in endemic form for millenia, its epidemic form is a relatively recent phenomenon, first scientifically documented in Sweden in 1887. Ironically, improvement in sanitation, purification of water supplies and pasteurization of milk, by suppressing the disease and leading to a precipitate decline in natural immunity levels, resulted in epidemic polio when the disease reemerged in susceptible populations. At the same time the average age of incidence rose from infancy to childhood and young adulthood and so too did the severity of the disease's symptoms.[1]

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Scandinavia and the northeastern United States consequently bore the brunt of the disease in the early 20th century, including 9,000 paralytic cases and 2,500 deaths which panicked New York City in 1916.[2] In Florida, however, polio was of little concern before World War II. The state's low expenditures for public health paradoxically seemed to keep the disease a minor endemic problem and immunity levels were consequently high. Only in 1925 did the morbidity rate approach 5 cases per 100,000.[3] The occasional cases, not surprisingly, received little assistance from the parsimonious state government. Although a 1906 law had provided for centralized care of crippled children, the program was never enacted. The State Board of Health provided limited assistance, but in 1921 its services were curtailed entirely when the Board's appropriation was cut during the governorship of Cary Hardee.[4]

Crippled Children's Commission ● In 1926, however, an event occurred which dramatically brought the sufferings of Florida's polio patients to public attention. In that year, W.A. "Doc" Huggins, sports editor of the *St. Petersburg Times*, masterminded the "kidnapping" of a little girl, suffering from polio, from the Pinellas county poor farm. Its Dickensian proprietors, paid a per diem rate for each resident, had refused to release the child for hospital treatment. Huggins, supported by the *Times'* editorial pages and assisted by Frank E. Weiser, post adjutant of American Legion Post 14, began a campaign for a charity hospital for Pinellas County's crippled children. Thanks to their efforts, the American Legion Hospital for Crippled Children, with space for 15 patients, opened the following year in an old St. Petersburg fruit packing plant that had been turned into a speakeasy by a gangster rumored to be linked to Al Capone.[5]

St. Petersburg's experience caught the imagina-

tion of 11,000 American Legionnaires throughout the state. At the 1927 state convention, Post 14 was the unanimous choice for the "community cup" award, and the organization resolved to declare work with crippled children a "major objective."[6] The following year, a Legion committee, chaired by Judge Walter S. Criswell of Jacksonville and assisted by other service organizations, surveyed the state to discover 700 crippled (not all from polio) and 309 blind children in need of care. Responding to the Legion's lobbying, the legislature in 1929 enacted the statute establishing the Florida Crippled Children's Commission with an initial appropriation of $50,000, roughly $50 per potential client. Governor Doyle E. Carlton called the Commission's first meeting on January 6, 1930.[7]

Although the Commission's funding seems grossly inadequate, even taking into account that Florida hospital costs were then only $2-$3.50 per day, its creation notably advanced welfare services in the state. The Council for the Blind was not created until 1941, while the Council on Mental Health was not established until 1955. Just as yellow fever had led to the founding of the State Board of Health following the Jacksonville epidemic of 1888, polio had been the occasion for this tentative venture in expanded public welfare.[8] It is a measure of the depth of concern for polio's ravages that the traditionally torpid legislature was shamed into funding a badly needed public service.

Nationally as well, poliomyelitis was becoming a public issue. In 1926, Franklin Roosevelt, with the assistance of his law partner Basil O'Connor, established the Warm Springs Foundation to support the health resort in Georgia where he had sought treatment for his paralyzed legs. In 1938, the Warm Springs Foundation became the National Foundation for Infantile Paralysis, undertaking as its first fund-raising project a public relations phenomenon, the March of Dimes, named at the suggestion of entertainer Eddie Cantor. In an avalanche of mail that took over five months to sort out, the Foundation received $1,823,043, including 2,680,000 dimes.[9]

With such unprecedented support for medical research, scientific interest in polio exploded. The emerging fields of virology and epidemiology contributed immensely to the understanding of polio, while other scientists conscientiously pursued various dead ends, spraying zinc sulfate in people's noses, eradicating flies, and championing various nutritional theories.[10] One of these, outlined in a *Science Digest* article entitled "Fruit Juices Speed Polio Onset," fortunately for Florida, proved useless, as did researcher Maurice Brodie's abortive 1935 attempt at vaccinations which ended in the death or paralysis of 13 people.[11]

Research seemed stymied at the outbreak of World War II but haunted by the 1918 pandemic of Spanish influenza, in which 43,000 American soldiers and sailors died of flu and pneumonia, the Defense Department gave high priority to medical research.[12] DDT, sulfa drugs, and penicillin were products of the war as well as two discoveries that contributed greatly to postwar research on polio, production of gamma globulin and development of a killed vaccine virus against influenza, discovered by Thomas Francis, later a mentor of Jonas Salk.[13]

More prevalent and severe ● At the war's conclusion, efforts to develop a vaccine against polio were resumed with increasing optimism. The need was great for polio in the late 40s was becoming more prevalent and more severe as postwar birth rates exploded. For the first time, southern states, including Florida, were experiencing significant outbreaks of the disease. In 1946 Florida surpassed the national average with 24.3 cases per 100,000. The following year the disease subsided to prewar levels, then resumed its upward climb, peaking in 1954 with 51 cases per 100,000.[14]

The account of a St. Petersburg man will enliven these statistics. A polio patient in the late 1940s, he "remembers the steaming hot packs applied to try to ease the pain so that he could sleep at night. He remembers one night trying to walk — not being able to stand the not-knowing — and reeling back to his bed, from weakness. He remembers the brace he wore for his back and stomach muscles for two years after 5 months in Crippled Children's Hospital. But most of all, he remembers a little boy, about 8 years old, who had a brace on every limb, on every finger, on every toe."[15] It is difficult to imagine today the sufferings of these polio patients, the ordeals of their families and the quiet heroism of the countless medical workers and hospital volunteers who worked daily with patients afflicted with this highly contagious disease.

The terror that polio engendered cannot be underestimated. Vacations to North Carolina, which experienced severe epidemics, were foregone by sweltering Floridians, and pools and movie theaters were off-limits to many children.[16] Although cancer, heart disease and accidents were far more realistic fears for parents, the dread inspired by leg braces, wheelchairs, and the terrifying iron lung, or Drinker respirator, returned every year with the summer's heat.

Fortunately, resources to cope with polio were increasing in the postwar era. The Florida Crippled Children's Commission treated 3,766 patients by the end of 1940, a figure spiraling to 11,181 by 1950.[17] The National Foundation for Poliomyelitis, rich with March of Dimes funds, provided significant assistance to polio patients, while the work of Australian nurse Sister Elizabeth Kenny, though medically controversial, encouraged more humane and less debilitating treatment of polio's victims. The 1946 Hill-Burton Act greatly expanded the country's hospital facilities. Twenty-one Florida hospitals accepted polio patients in 1950, including the specialized Pinellas American

Legion Home for Crippled Children, now expanded to 62 beds, and Hope Haven Crippled Children's Hospital in Jacksonville. The best hospitals, equipped for long-term care of young polio patients, had in-house schools and swimming pools for physical therapy. With no cure for polio, however, the National Foundation could only state that "The objective of a good institution is to turn out a person who is emotionally adjusted to his situation and prepared to make the most of life."[18]

An encouraging development in polio prevention was the growing use of gamma globulin, developed during the war and field tested for polio in an epidemic in Provo, Utah, in 1951. Expensive, painful to administer in 10 cc doses, and conferring only temporary immunity, gamma globulin was used only in epidemic situations.[19] In 1954, the Florida State Board of Health dispensed approximately $2,100,000 worth of the serum, provided by the National Foundation for Infantile Paralysis and the Red Cross, primarily for mass immunizations in Monroe, Broward, and Leon Counties.[20]

Preventative vaccine ● Hopes were high for a preventative vaccine against polio. In 1949, a Harvard team led by John Enders had successfully cultivated polio virus in human tissue and in 1952 researchers David Bodian and Dorothy Horstmann discovered that the virus was a widespread intestinal infection that reached the nervous system through the bloodstream. A vaccine now seemed possible and the National Foundation's fund raising campaigns yearly hailed new breakthroughs. By 1954 Jonas Salk of Pittsburgh was ready to begin trials of a killed virus vaccine which used virus particles inactivated by formaldehyde to induce immunity.[21]

Although Florida was far from the centers of polio research, in the spring of 1954 second grade students in Palm Beach and Broward Counties became "Polio Pioneers" in the Salk vaccine trials, in which 1,800,000 children participated nationwide.[22] The need for an effective vaccine was felt with particular urgency in Florida. Though 1952 had been the peak epidemic year in the country at large, with a case rate of 37.2 per 100,000 and more children dying of polio than of any other infectious disease, 1954 was Florida's plague year, with 1,777 cases, 51 cases per 100,000, a rate almost twice as high as any previous year. Fifty-five cases were fatal.[23] The state's newspapers kept ghoulish counts of new polio cases, listing new patients by name and address, a policy which must have caused panic in affected neighborhoods.

Leon County was by far the hardest hit, reporting 408 cases for 1954, most occurring in white women aged 20-40.[24] As the full force of the epidemic hit in September and October, medical facilities were seriously strained. At one point, 125 cases crowded Tallahassee Memorial Hospital which borrowed beds from Florida State University and Florida A&M University infirmaries.[38] Both the hospital's administrator and business manager contracted polio and five members of the family of a public health doctor had the disease.[25] As the number of cases grew higher dramatic stories were reported such as the 23-year-old woman who gave birth to a healthy son while confined to an iron lung.[26] On October 8, the *Tallahassee Democrat* warned, "Let's be calm," in a front page editorial, and on October 12, Wilson T. Sowder, M.D., who has been head of the Florida State Board of Health for nine years, said, "I have not seen a communicable disease that has disrupted a community. . . as this has."[27] Nonetheless, though the state bar examination and several high school football games were canceled, Leon County's schools and universities remained open and state business went on as usual.[28]

But the impulse to "do *something*" was irresistible. Acting Governor Charlie Johns called in the out-of-town experts, in this case the United States Public Health Service, and appealed for federal aid.[29] Joseph M. Bistowish, M.D., Leon County health officer, began a program of house fly eradication. Broward County offered its spray planes used in Everglades mosquito control projects although the National Foundation had determined by 1951 that insect control had no appreciable effect in controlling epidemics. Dr. Bistowish asserted that although the effectiveness of DDT spraying had not been demonstrated, it wouldn't do any harm.[30] The state, under an obscure statute which Attorney General Richard Ervin resurrected from the days of smallpox epidemics, granted the county $25,000 and loaned it an additional amount to assist with its unprecedented hospital and public health expenses.[31] The most useful measure, perhaps, in soothing the city's fears was the *Democrat's* and the Leon County Medical Society's sponsorship of a "Polio Medical Forum."[32]

Nature, however, played the deciding hand, and the epidemic subsided as cooler weather arrived in mid-October. Most cases of "Tallahassee polio" eventually recovered completely, and the Board of Health speculated that perhaps some organism other than polio virus was responsible for most of the cases.[33]

Assessing vaccine trials ● While Tallahassee suffered, the National Foundation's Vaccine Advisory Committee began assessing the results of the Salk vaccine trials, including the small contribution of Palm Beach and Broward Counties' second graders. Thomas Francis, Salk's former teacher, was given the job of processing and evaluating the massive data generated by the study.

On April 12, 1955, the tenth anniversary of Franklin Roosevelt's death, Dr. Francis announced his conclusions. The news of the trial's apparent success electrified the country. Incredibly the Salk vaccine was approved in two hours by Surgeon General Leonard A. Scheele and Secretary of Health, Education and

Welfare Oveta Culp Hobby, who conferred with Dr. Francis's team over an open telephone line while television cameras whirred. As they spoke, 10,500,000 doses of vaccine were ready for immediate distribution.[34] As early as March, according to L. L. Parks, M.D., director of the State Board of Health's Bureau of Preventable Diseases, parents of 85% of the state's first and second grade students had already authorized their children's vaccinations as soon as the serum was available.[35]

Overnight, Jonas E. Salk was a hero. Florida newspapers were exultant. To the *St. Petersburg Times*, Salk was "the Man of the Century."[36] The *Tampa Tribune* hailed "V-J day against polio", and the *Miami Herald's* columnist Jack Bell elaborated on the theme: "The best news ever given to mankind was that World War II was ended. Next on the list is the story of the vaccine that will prevent polio."[37] The war on polio, it was widely agreed, had been fought and won with millions of school children's dimes as ammunition.

With memories of its recent encounter with polio's horror still fresh, Tallahassee moved quickly to provide vaccine for the state's poor children. State Representative Thomas D. Beasley of Walton County and 69 cosponsors immediately introduced a bill to buy $1,000,000 worth of vaccine for the indigent, making Florida, reported the *Miami Herald*, "the first among the 48 states to move to provide broad inoculation among its populations."[38] Though cut to $550,000 on the recommendation of the Board of Health's Dr. Sowder, surely an atypical bureaucrat, who pointed out that first and second graders would receive free vaccine from the National Foundation, the measure was rushed through appropriate committees with minimal opposition.[39] The urgency of the undertaking was underscored by the announcement of a National Foundation spokesman on April 16 that 118 cases of polio had already been reported in Florida, in contrast to 113 at the same point in 1954, the worst year yet for the disease.[40]

Massive inoculations ● Medical personnel, community groups, and individuals rushed to donate time, money, and lollipops, and plans to organize the massive program of inoculations were quickly formulated. Five-year-old Inez Johnson of Miami received the state's first privately administered injection, given by Dr. Meyer Marks.[41] Duval County, first to receive the National Foundation's free supplies of vaccine for first and second graders, began Florida's first public vaccination program.[42] Other counties soon followed as vaccine supplies became available, but on April 28, parents and public health officials were shaken by reports that serum manufactured by the Cutter Company of California had been linked to paralytic polio in six vaccinated children. A stream of lawsuits soon followed.[56] Quickly, the Florida State Board of Health assured residents that most of its vaccine had been manufactured by Eli Lilly, rather than Cutter, and vaccination programs resumed.[43] An estimated 300 doses of Cutter vaccine had reached the state, however, although no polio cases were associated with it. On May 8, a shocked nation learned that all vaccinations had been halted pending further study. Approximately 150,000 Florida school children (4-5 million nationwide) already had been inoculated.[44]

Outside the scientific community, few Americans had any inkling of the controversies that for years had swirled around Jonas Salk and his killed virus vaccine. Ever since the abortive Brodie vaccine in the 30s, a killed virus vaccine had been looked on with suspicion. The problem is, Greer Williams writes, "that there are upwards of ten million virus particles in one vaccine dose and that the last one requires just as much killing as the first."[45] While Salk and his Pittsburgh team rushed their vaccine to production, other researchers, notably Herald Cox and Hilary Koprowski at Lederle Laboratories and Albert Sabin of the University of Cincinnati, were developing attenuated vaccines, using live viruses which had been weakened by passing them through many generations of living tissue.[46]

While politicians and scientists debated, Florida's rising heat and humidity gave a sense of urgency to the resumption of the vaccine program. On June 7, Surgeon General Scheele lifted the ban and vaccinations quickly resumed. Unfortunately, five Florida children who previously had been inoculated developed polio, but Dr. Parks assured the state that the cases had occurred "before immunity developed."[47] Despite this, and even though most public schools had adjourned for the summer, few children failed to return for their second series of shots. In Pinellas County, where schools remained in session for three extra days to complete the vaccine program, Director of Public Health William Ballard, M.D., estimated that only 5% of children withdrew from the program.[48] In rural Nassau County, which did not extend classes, only 20 children of the original 240 vaccinated did not return.[49] In other areas of the country, the "dropouts" had been as high as 30%.[50] Florida had been fortunate in receiving primarily vaccine manufactured by Eli Lilly, one of the first companies to be cleared by the Public Health Service.[51] Also, county health departments were strongly supportive of the vaccine. Dade County's health director T. E. Cato, M.D., on May 12, declared his conviction that the vaccine had proven safe and effective, while Pinellas County's Dr. Ballard asserted that the ban assured that "when the vaccine arrives. . . for the second inoculation we can be doubly sure of its safety."[52] DeSoto, Hardee and Charlotte Counties, in fact, continued their planned inoculations, for which they had already received vaccine, after the May 8 ban on new distributions of serum had been announced.[53] Florida's 1954 experience with polio was a powerful incentive to welcome the new vaccine.

In Tallahassee, on June 12, Dr. Parks announced the details of Florida's vaccine distribution program. The $550,000 which the legislature had granted in April would pay for 13% of the state school children's inoculations, while 25% more would be assisted by Florida's share of the recently released federal funds. All first and second graders would receive free vaccine from the National Foundation. The remainder would be urged to receive shots from their private physicians at an average cost of $4 to $6.54.

By 1956, over one million people had been immunized in Florida and cases of polio within the state began to drop precipitiously, with 466 cases in 1955, 364 in 1956, and 134 in 1957.[55] Nevertheless, in Florida, as in the country at large, it was becoming evident in the late 1950s that Salk vaccine was an imperfect solution to the problem of polio. Albert Sabin, who had continued research on his live virus vaccine while engaging in rear guard attacks on the Salk product, had helped to keep the controversy alive.

Public health officials were having difficulty persuading parents to follow up on the three shots plus annual booster regimen of Salk vaccine. In Dade County, for instance, a five year injection program had reached only 78% of the targeted population. Blacks and Latins had proved especially difficult to reach, and the Board of Health was reporting an alarming increase in the proportion of polio cases among blacks.[56] In 1963, it reported that the annual average case rate in the post-Salk period was 2.0 per 100,000 for whites vs. 2.4 for nonwhites, compared with 24.6 for whites and 7.6 for nonwhites in the pre-Salk years.[57] In a series of surveys carried out throughout the state, the Board of Health found that over 80% of children from urban, white, middle class groups were immunized, but less than 30% of blacks and disadvantaged white children were protected.[58] What had been primarily a middle- class affliction was now more often found among the lower class, lower income groups that public health departments failed to reach. Supporters of the live virus vaccines argued that vaccination rates would rise substantially if the country converted to an easily administered one dose oral vaccine. In addition, the live vaccines would provide a quicker, longer-lasting immunity.[59]

Oral vaccine ● By 1960, Dade County officials, troubled by continuing cases of polio, 46 in 1959 despite a county-wide Salk injection program including seven among Salk-vaccinated individuals, became the first in the United States to test an oral live vaccine, a brand developed by Herald R. Cox of Lederle Laboratories.[60] The Lederle vaccine's chief competitor, developed by Albert Sabin, had been field tested in Russia from 1957 to 1959. With the assistance of the University of Miami School of Medicine, Dade County Medical Association, and numerous volunteers, the Dade County Health Department began administering the Lederle vaccine on February 16, 1960, attempting to reach all county residents under age 40.[61] By the end of the program in April, almost 415,000 residents had been immunized with the cherry flavored liquid.[62]

Unfortunately for Cox and for Lederle Laboratories, which had invested $10,000,000 in Cox's vaccine, seven cases of paralytic polio did develop in Dade County and 23 others were reported in West Berlin, which had run concurrent tests.[63] Sabin had won the day, and on August 24, 1960, Surgeon General Leroy Burney made the winner official. This time, however, the government proceeded cautiously and not until March 1962 was the third and final strain of the vaccine officially licensed.[64]

Nevertheless, by the summer of 1962, a familiar drama was being replayed. The problem with killed virus vaccines was the difficulty in ensuring that every virus particle had been inactivated. With attenuated strains of live viruses, the fear was that weakened viruses would "revert to virulence" through mutation and spread from person to person.[65] By September there were over 60 reported cases of polio among the vaccinated. After painstaking examination, the Oral Poliomyelitis Vaccine Advisory Committee of the Public Health Service determined that adults over 18 were especially susceptible to problems with the vaccine and would receive it only in "extraordinary circumstances." The Public Health Service remained committed to the Sabin vaccine, although it proposed various revisions in its manufacturing processes.[66]

In Florida, after careful field tests, the Board of Health gradually converted its vaccine program to the Sabin product. Florida's parents obediently lined up their children for the new, improved product.[67] In addition to the formally vaccinated, it is thought that the natural immunity conferred by the Sabin vaccine spreads throughout the uninoculated population in a benign echo of the early epidemics.[68] Soon the Florida State Board of Health was able to announce, in an exclamatory sentence surely unprecedented in its statistical publications, that "In 1965 no confirmed case of poliomyelitis was reported!"[69]

Conclusion ● Today polio is an extremely rare disease, never encountered by most physicians. Despite the success of the Sabin vaccine, controversies still surround its use, and the Salk/Sabin question is very much alive.[70] Since 1979 all cases reported, 15 nationally in 1983, have ironically resulted from the Sabin vaccine rather than from a "wild" virus.[71]

Although polio has virtually disappeared, the charitable institutions that Florida's polio epidemics engendered remain, their missions vastly expanded, their origins mostly forgotten. Polio wards in the state's general hospitals have been remodeled and specialized polio hospitals have been reconstituted into general children's hospitals, their charity programs

long since displaced by Medicaid and private health insurance. In St. Petersburg, the American Legion Hospital for Crippled Children became All Children's Hospital in 1967 and Hope Haven Hospital in Jacksonville was absorbed by Nemours Children's Clinic, sharing in the $100 million estate of financier Ed Ball.[72] The Florida Crippled Children's Commission was merged into the Department of Health and Rehabilitative Services following the state constitutional reform of 1968. The March of Dimes, too, has found a new and broader function, the treatment and prevention of birth defects, and, dimes not being what they were, has turned to telethons for most of its fundraising.

An estimated one fourth of Florida's surviving 6,218 victims of the 1946-1960 epidemics are at risk for "post polio syndrome," a condition in which the normal cell loss of aging, combined with the irreversible lesions of polio, result in progressive weakness of the muscles originally affected.[73] For these survivors, the nightmare is beginning again. For most Floridians, however, poliomyelitis, like yellow fever and pellagra, has mercifully receded into history.

Notes

1. John R. Paul, A History of Poliomyelitis (New Haven: 1971), 11: Aaron E. Klein, Trial by Fury: the Polio Vaccine Controversy (New York: 1972), 8; Greer Williams, Virus Hunters (New York: 1959), 242; Monroe Lerner and Odin W. Anderson, Health Progress in the United States, 1900-1960: a Report of the Health Information Foundation (Chicago: 1963), 154
2. Klein, Trial by Fury, 6; Paul, Poliomyelitis, 145-152: John Rowan Wilson, Margin of Safety (New York: 1963), 145-160.
3. Florida. State Board of Health, Morbidity Statistics, 1955 (Jacksonville: 1956), iv.
4. Florida. Crippled Children's Commission. Report of the Florida Crippled Children's Commission, 1930-1962 (Tallahassee: n.d.), 4.
5. St. Petersburg Times, February 11, 1962; Frederick Eberson, Early Medical History of Pinellas County: a Quadricentennial Epoch (St. Petersburg: 1978), 109-110.
6. American Legion Post 14, St. Petersburg, FL 1927 Scrapbook.
7. Florida. Crippled Children's Commission. Report, 1930-1962, 4
8. Allen Morris, compiler, The Florida Handbook, 5th biennial ed. (Tallahassee: 1955), 197, 205, 212; Charlton Tebeau, A History of Florida (Coral Gables: 1971), 291.
9. Klein, Trial by Fury, 14-22; Richard Carter, Breakthrough: the Saga of Jonas Salk (New York: 1966), 12-18.
10. Klein, Trial by Fury, 34-43; Paul, Poliomyelitis, 132; Steven Lehrer, Explorers of the Body (Garden City, N.Y.: 1979), 391.
11. "Fruit Juices Speed Polio Onset," Science Digest (June 1947), 34; Klein, Trial by Fury, 20-21; Wilson, Margin of Safety, 2; Paul, Poliomyelitis, 254-259.
12. Alfred W. Crosby Jr., Epidemic and Peace, 1918 (Westport, Conn.: 1976), 206.
13. Klein, Trial by Fury, 36-40, 62, 70-71.
14. Florida. State Board of Health, Morbidity Statistics, 1954, iii.
15. St. Petersburg Times, September 2, 1973.
16. Ibid.
17. Florida. Crippled Children's Commission, Report, 1930-1962, 18.
18. Maxine Davis, compiler, "First Complete Handbook on Infantile Paralysis," Good Housekeeping (August 1950), 199.
19. Klein, Trial by Fury, 62, 70-71; Carter, Breakthrough, 104; Paul, Poliomyelitis, 392-394
20. Florida, State Board of Health, Annual Report, 1954 (Jacksonville: 1955), 63.
21. Paul, Poliomyelitis, 369-394; Carter, Breakthrough, 114, 132-135.
22. Florida. State Board of health, Annual Report, 1954, 63; Klein, Trial by Fury, 97-98, 102-103; Williams, Virus Hunters, 304-305.
23. Florida. State Board of Health, Annual Report, 1954, 64; Paul Starr, Social Transformation of American Medicine (New York: 1982), 346; Lerner and Anderson, Health Progress, 153; Florida. Bureau of Vital Statistics, Vital Statistics, 1954 (Jacksonville: 1955), 6.
24. Florida. State Board of Health, Morbidity Statistics, 1954, iv.
25. Tallahassee Democrat, September 20, 1954; October 7, 1954.
26. Ibid, October 24, 1954
27. Ibid, October 8, 1954; Octoher 12, 1954
28. Ibid, October 6, 1954; September 28, 1954, Tampa Tribune, October 9, 1954.
29. Tallahassee Democrat, October 7, 1954; St. Petersburg Times, October 7, 1954
30. Tallahassee Democrat, September 26, 1954; October 10, 1954; Davis, "First Complete Handbook on Infantile Paralysis," 201
31. Florida. State Board of Health, Annual Report, 1954, 1; Tallahassee Democrat, October 12, 1954.
32. Ibid, September 9, 1954; September 15, 1954.
33. Florida. State Board of Health, Morbidity Statistics, 1954, iv.
34. Williams, Virus Hunter, 295-320; Klein, Trial by Fury, 107-113; Paul, Poliomyelitis, 426-435; Carter, Breakthrough, 268-284.
35. Tampa Tribune, April 19, 1955.
36. St. Petersburg Times, April 13, 1955.
37. Tampa Tribune, April 13, 1955; Miami Herald, April 13, 1955.
38. Miami Herald, April 14, 1955.
39. Ibid, April 15, 1955; St. Petersburg Times, April 16, 1955; April 20, 1955.
40. Miami Herald, April 17, 1955.
41. Tampa Tribune, April 15, 1955.
42. Miami Herald, April 17, 1955.
43. St. Petersburg Times, April 28, 1955.
44. Miami Herald, May 8 1955; Paul, Poliomyelitis, 438; Bert Spector, "The Great Salk Vaccine Mess." Antioch Review 38 (Summer 1980), 299.
45. Williams, Virus Hunters, 332.
46. Ibid, 346-349; Klein, Trial By Fury, 127-151; Paul, Poliomyelitis, 441-462.
47. Miami Herald, June 13, 1955.
48. St. Petersburg Times, June 10, 1955.
49. Gertrude Blatchford (public health nurse of Nassau County), Papers, Florida Museum of Transportation History, Fernandina Beach, FL.
50. Carter, Breakthrough, 327.
51. Miami Herald, May 16, 1955.
52. Ibid, May 12, 1955; St. Petersburg Times, May 9, 1955.
53. Miami Herald, May 10, 1955.
54. St. Petersburg Times, June 13, 1955; April 15, 1955.
55. Florida. State Board of Health, Annual Report, 1956, 27; Florida, State Board of Health, Morbidity Statistics, 1955-1957.
56. Albert L. Johnson, et al., Epidemiology of Polio Vaccine Acceptance; a Social and Psychological Analysis, Monograph No. 3, Florida State Board of Health (Jacksonville: 1962), 4, 36.
57. Florida. State Board of Health. Morbidity Statistics, 1963, v.
58. Florida. State Board of Health, Annual Report, 1960, 100.
59. Paul, Poliomyelitis, 451.
60. New York Times, February 16, 1960; Klein, Trial by Fury, 145.
61. Miami Herald, February 11, 1960; February 15, 1960.
62. Ibid, August 25, 1960.
63. Wilson, Margin of Safety, 221.
64. Carter, Breakthrough, 380; Klein, Trial by Fury, 147-149.
65. Ibid, 152-153.
66. Ibid, 149-150; Carter, Breakthrough, 381-383.
67. Florida. State Board of Health, Annual Report, 1961, 77; Annual Report 1962, 96-97; Blatchford Papers.
68. Klein, Trial by Fury, 152.
69. Florida. State Board of Health, Morbidity Statistics, 1965, v.
70. Daniel Jack Chasan, "The Polio Paradox," Science 86 (April 1986), 37-39; Charles L. Mee, Jr., "The Summer before Salk," Esquire (December 1983), 44.
71. United States. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1986, 106th ed. (Washington: 1985), 18; Joy Horowitz, "Polio's Painful Legacy," New York Times Magazine (July 7, 1985), 18; Chasan, "The Polio Paradox," 37-38.
72. Eberson, Medical History of Pinellas County, III; Walker Roberts, "Passing of an Era," Florida Trend (August 1981), 102.
73. Horowitz, "Polio's Painful Legacy," 17.

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SPECIAL ARTICLE

History of Hysterectomy

Guy I. Benrubi, M.D.

During the last 170 years, gynecologists have proceeded from the first tentative attempts to perform hysterectomies to the present where approximately 680,000 such procedures are done yearly. Hysterectomy is now the second most commonly performed operation in the United States. Approximately one half of American women will have a hysterectomy by the time they reach age 70. The hospital cost alone is approximately $3 billion annually.

In order to understand how this procedure has become so popular, we must return to an examination of its early development. For as Shakespeare said, "What is Past is Prologue."

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Early development ● In early history the uterus was known because of anatomical studies. Aristotle considered the uterus the "seat of womanhood." Though there are several descriptions and references made to removing the uterus, there is no definitive evidence that this operation was performed prior to the 16th century. Soranus, the Greek obstetrician practicing in Alexandria and subsequently in Rome in the 2nd century, seems to have originated the idea of removing the uterus through the vagina. Galen apparently developed an early vaginal speculum which enabled some intravaginal work and possibly some removal of portions of the uterus. Aretaeus and Paulus Aeginata referred to the operation in their writings. Alsaharavius in 1080 directed that if an organ was prolapsed and could not be reinserted then it should be removed from below.

Berengarius of Bologna in 1507 is given credit for having described the first authenticated removal of the uterus through the vagina. It is quite possible that Berengarius only removed a portion of the uterus. Andreas of Cruce has also been given credit for having performed the first vaginal hysterectomy in 1560. At the same time Ambrose Pare might have performed a partial extirpation for an inversion of the uterus as early as 1575. Despite the long "Dark Ages" of information concerning hysterectomy during the 500 years between Alsaharavius and Berengarius, it is quite possible that vaginal hysterectomy was performed in a crude manner by midwives and others for inversion of the uterus during delivery. Several reports of these primitive procedures have been recorded. J. Schench of Grafenberg in 1617 related a number of cases in which the uterus in whole or in part was removed from the vagina because of prolapse during delivery. Fabricus Haldanus (1560-1624) reported instances of partial or complete removal of the uterus by midwives during inversion of the organ at delivery. There is at least one documented case of a self-inflicted hysterectomy which was reported

by Percival Willoughby in his "Observations in Midwifery" which was published about 1670. He describes the somewhat tragic story of Faith Raworth thus:

> ***Striving to lift a heavy coale, and to carry it farther, than her strength would well permit, perceived something to crack in her back. That night she suffered lapsus uteri. She oft put it up, but it would presently fall down again. Being troubled and discontented, and wearied with this affliction, in hopes to cure herself, she went into the garden and laying hold on it drew it, and cut it forth, with part of the vagina.***
>
> ***A great flux of blood followed with fainting. She swooned and was taken up, more likely, presently to die, than to recover. The wound was great and deep, and she has cut off some of the fleshy part of the neck of the bladder with all of the womb, and could not, then hold her water, seeking help to stay her water and finding none, at last she came to me, I could pass my finger through the wound into the bladder. I scarified the place where the wound was made, and with double twisted silk I stitched it up. Whilest the stitches did hold, water came by the right passage. But when they separated her urine issued again by the old breech. It grew narrower, and lay deep. It could not at last be perceived where the orifice was, through which the water dribbled. She lived several years with this affliction and died uncured, her water always coming night and day, insensibly dribbling from her.***

A similar case was reported by Volkamer of Nuremberg in 1675.

During the 18th century, physicians observing similar isolated cases of midwives doing these operations reported some tentative attempts on their part to perform a similar type of procedure. Apparently William Hunter (1718-1783) did perform such a procedure with resulting death of the patient. Wrisberg writing in 1787 described how a midwife removed a prolapsed uterus after delivery using a kitchen knife. He suggested that a similar procedure can be done under more controlled conditions. In 1792 Laumonier removed an inverted uterus after tying a ligature around its base. The patient died six weeks later. In a postmortem there was obliteration of the vagina, absence of the uterus, and the ovaries and tubes were found on either side of the rectum.

In the last decade of the 18th century Osiander of Gottingen developed Wrisberg's ideas further and decided that at least a partial hysterectomy could be performed through the vagina. He, in fact, completed such a procedure in May 1801. He performed a total of ten similar procedures and reported these in 1808.

In the 19th century major advances in the surgical removal of the uterus were made. This century saw major technical advances as well as two developments which would be crucial in hysterectomy as well as the practice of all surgery. These were the development of anesthesia, discovery of antisepsis and development of antiseptic technique.

However, even before the advent of antisepsis and anesthesia, seminal attempts at hysterectomy were accomplished. These successes were in vaginal hysterectomy. Intraabdominal surgery in the early 19th century was too risky to truly be efficacious for removal of pelvic organs.

In the early 19th century, there were two indications for vaginal hysterectomy, prolapse or chronic retroversion of the uterus, and cervical cancer. Almost all of Osiander's cases, were done for the latter. It soon became apparent that a partial removal of the uterus for cervical cancer was not of any value, as the patient rapidly died from persistent disease within the year. Wenzel in 1816 in his book on diseases of the uterus showed that Osiander's amputations led to rapid reappearance of disease and death of the patient. Attempts similar to Osiander's were those of Dupuytren (1778-1835). Dupuytren developed the technique of grasping the uterus with a tenaculum, bringing it down toward the vaginal introitus and then amputating the diseased cervix. At the turn of the century, he reported 29 cases where he had removed a carcinoma of the cervix, and claimed 14 successes. However, a later report by Pauly on Dupuytren's statistics showed that only one of Dupuytren's patients survived. These dismal results induced Dupuytren to abandon his procedure and instead use cautery on the carcinomatous parts.

During this same first decade of the 19th century, while the first tentative steps were being made toward vaginal hysterectomy, Ephraim McDowell developed the first abdominal surgical gynecological procedure by doing the first ovariectomy. Forty years later, this procedure would lead to the first attempts at abdominal hysterectomy. But during the first half of the 19th century removal of the uterus remained a vaginal operation. Because of the somewhat unorganized and chaotic state of the medical literature, it is difficult to decide who was the first physician to perform each new operation. Therefore, competing claims have resulted as to the pioneer of many surgical procedures.

Beaudeloque between 1800 and 1816 reputedly performed 23 vaginal hysterectomies, although probably these were partial procedures. He gave credit to the initiation of this procedure to Lauvariol who supposedly developed this technique in 1783. In 1812 Palletta, the Italian surgeon, removed the entire uterus through the vagina. Many have credited him as having done the first complete vaginal hysterectomy. He was not attempting to remove the entire organ but only to do a high amputation of the cervix. He was truly amazed when on examination of the specimen he realized that the whole uterus had been removed. This procedure was performed on April 13, 1812. He accomplished it by using obstetric forceps to pull the uterus down towards the vaginal introitus as well as pushing it from above the pubis by an assistant. The patient died on the third postoperative day.

First intentional complete extirpation of uterus ● The man who is often credited as having performed the first deliberate, well-planned vaginal hysterectomy was C.J.M. Langenbeck of Gottingen, Germany in 1813. He used the works of Wrisberg and the description of Palletta's case to undertake his procedure. It is also probably the first case of total vaginal hysterectomy where the patient survived. The operation was performed on Ms. Overschein who was 50 years of age and the mother of several children. She had a prolapsed uterus with an ulcerated nodular cervix. Whether in fact this was a cervical cancer or induration and ulceration secondary to the cervical prolapse is hard to determined from the available literature. The patient was placed on the edge of a bed with thighs extended and feet resting on two stools. Langenbeck dissected the vagina from the cervix until the peritoneal reflection was identified. He took special precautions not to enter the peritoneal cavity. The broad and round ligaments, paracervical attachments, and fallopian tubes were divided. He did a subperitoneal enucleation of the fundus of the uterus, thus avoiding entry into the peritoneal cavity. Because of the last step, he was often attacked as having not done a truly complete vaginal hysterectomy. During the procedure the patient suffered severe hemorrhage and nearly died. She was revived by splashing cold water over her face. With no one to assist him Langenbeck had to tie his ligatures using one hand and his teeth. After the operation the vagina was packed with a sponge. Despite the dramatic intraoperative condition of the patient she survived and made an uneventful recovery. She died 26 years later.

"Sightless exam" taken from a textbook on obstetrics and gynecology, C-1834

Langenbeck's initial claim was that he not only removed the uterus through the vagina but also the ovaries. This was because during his first inspection of the specimen he found two hard masses on the uterus. These were later interpreted as being fibroids. Because of his claim of removal of the uterus and ovaries without entering the peritoneal cavity, Langenbeck's claim was met with skepticism and a great deal of scorn. It was not until the postmortem examination was performed on this patient 26 years after the operation that it was noted that the uterus had been completely removed. As the specimen was lost soon after the operation, and as there were no other people that could verify his procedure, his assistant having died shortly afterwards, it is still not known whether in fact this patient had carcinoma of the cervix. Nevertheless, Langenbeck is credited as having performed the first intentional complete vaginal extirpation of the uterus.

Despite Langenbeck's success this operation was so fraught with morbidity and mortality that for many years it was not an accepted procedure by a large part of the medical profession. At the same time as Langenbeck was performing his first procedure, several isolated instances of vaginal hysterectomy were recorded. In the United States, in Charleston, South Carolina, a procedure on a patient who had a prolapsed uterus was carried out by the surgeon Joseph Glover, who tied a ligature around what he felt was the uterus and then cut the organ below the ligature. Again it is difficult to decide from the description of the case whether a hysterectomy was performed or whether this was a prolapse of an endometrial tumor or some other malignancy.

Four years later in 1817 in Great Britian John Windsor performed a procedure on a patient who had a chronic inversion of the uterus. This again was done by tying a strong silk ligature around the prolapsed organ and then cutting below the ligature without incurring any hemorrhage. Several of these procedures were described around the time. It is probably safe to assume that most of these were supracervical hysterectomies, the ligature was tied around the inverted fundus and did not include the cervix.

Further refinements of the operation were achieved by J.N. Sauter in France. In 1822 he performed an operation on a uterus that was not prolapsed. He also was the first to enter the peritoneum in order to remove the whole organ. Because Langenbeck had not entered the peritoneum, many have credited Sauter as having performed the first truly transvaginal hysterectomy. Later Sauter reported on 25 vaginal hysterectomies with only four survivors. Sauter gave a detailed description of his procedure. It is important to note that these procedures were done without the benefit of hemostats or any other clamps. The tissues that were incised were ligated, but this was done by gross and inefficient means. Many of these procedures resulted in vesicovaginal and rectovaginal fistulas.

Langenbeck's second operation was on August 5, 1825 at which time he performed a procedure on a 28-year-old servant woman. Here Langenbeck refined his technique and was the first operator to enter the pouch of Douglas as a first step. He then introduced his hand into the peritoneal cavity grasped the fundus of the uterus, inverted it, brought it down towards the vaginal introitus, and completed the procedure. A sponge was again left in the vagina, and 20 leaches were applied on the abdomen to relieve abdominal pain. The patient died on the second postoperative day, apparently from overwhelming peritonitis.

The first American vaginal hysterectomies, other than the one described by Glover, (ligature type of procedure) were probably performed by French surgeons

who had moved to New Orleans. The first authenticated American procedure was performed by John Collins Warren of Boston in 1829. Apparently the patient died on the fourth postoperative day.

The next important advance was by Recamier in 1829. He refined the techniques that had been described by Sauter and performed a vaginal hysterectomy by entering the peritoneal cavity and, more significantly, using ligatures on the uterine arteries. Recamier's procedure was performed in 20 minutes and the patient survived the postoperative period but later died of cervical cancer which had been the indication for the operation. Another important advance by Recamier was the introduction of his specially designed vaginal speculum.

Retreat and advances ● By 1830 several reports were made in the existing literature reviewing series of vaginal hysterectomies. It became quite obvious that the operative mortality was close to 90%. The long-term prognoses were equally dismal since these cases were performed for cervical cancer and the patient invariably died. Between 1830 and 1850 a dissatisfaction with this procedure ensued. The technique often led to rectal and bladder injuries and the cause of death was peritonitis.

An example of the discontent with which this operation was met is exemplified by the writing of Dieffenbach, one of the greatest German surgeons of his time (1792-1847):

> ***To take the entire womb from the belly of a woman means the removal of that woman's soul even if it be a diseased soul. Still, some daring men attempted it and they deserve our thanks in as much as the results of their terrible operation furnish us all the proof needed to banish this procedure from the field of surgery. According to my opinion, an indication for this operation does not exist. The attempted extirpation of the womb partakes more of the character of murder tales than of curative surgical operations.***

In the 1830s a revolution in medical thinking began to occur in the hospitals of Paris. During the preceding three decades the reforms of the French Revolution and of the Napoleonic Era led to the questioning of all entrenched dogma and institutions. Among these were the existing dogmatic thoughts on medicine, especially those concerning "constitutional pathology" and the approach to disease. For the first time empiricism entered the practice of medicine and the French physicians were able to observe the outcome of specific treatments on their patients as they followed these patients from the hospital ward to postmortem examination. The existing practices of bleeding, purgation, and emetics were found to be wanting. It was this revolution in thought that led to the various new techniques in medicine such as antisepsis, cellular pathology, and experimental medicine.

In mid-century Semmelweis in Vienna discovered how inappropriate aseptic technique resulted in death of his female patients. Somewhat later Lister described the use of antiseptic technique to cut down on postoperative infections. In the 1840s Crawford Long, a physician in Georgia, observed participants in ether frolics. He noticed that when they hurt themselves during these frolics they had no memory of their injuries and experienced no pain. He deduced that ether would be useful for surgical anesthesia. These two great developments in the mid — 19th century, anesthesia and antiseptic technique, allowed further advances in surgery and particularly in hysterectomy, vaginal as well as abdominal.

As mentioned previously Ephraim McDowell performed the first ovariectomy in the United States in 1809. This operation had become an accepted and frequently performed procedure. It led inadvertently to the first supracervical abdominal hysterectomy in 1843. Prior to that because of the lack of appropriate hemostasis and because of the invariable peritonitis that would result, intraabdominal uterine removal was looked upon as impossible and unthinkable. Thus it is no surprise that the first hysterectomy performed by Heath was in fact an inadvertent procedure. Heath was a lecturer on midwifery in the Manchester School of Medicine and Surgery. He had started his surgical case because he felt that he was operating on an enlarged ovary. The procedure took place on November 21, 1842. After entering the peritoneal cavity it became obvious to Heath that "tumor was part of the uterus and was distended by solid matter." This was rendered even more certain by the introduction of a trocar which was standard technique for ovariectomy. The trocar revealed that he was dealing with a solid mass. In Heath's words:

> ***I raised the fundus of the uterus from the abdominal cavity. Two double ligatures were passed by means of a sharp pointed aneurism needle through the cervix uteri immediately below the circumference of the tumor. Each ligature was then firmly tied so as to include one half of the neck of the womb and broad ligaments. The parts were then excised and removed. No bleeding ensued from the cut cervix. After the first division of the skin, few complaints of suffering were made by the patient herself.***

The patient died 13 hours after the completion of the procedure.

A little more than a year later Charles Clay, one of the more famous ovariatomists, performed a total abdominal hysterectomy and bilateral salpingo-oophorectomy on January 16, 1844. Although there is some controversy as to whether or not his procedure was a total hysterectomy it was certainly the first procedure that included the removal of the uterus as well as both ovaries. Clay's patient died on the 15th postoperative day.

The first deliberate supracervical hysterectomy for fibroid uterus with a correct preoperative diagnosis was

performed by the American surgeon John Bellinger (1804-1860) in June 1846. The operation was completed, but the patient died from resultant peritonitis on the fifth postoperative day.

The first successful abdominal hysterectomy was performed by Walter Burnham (1808-1883) who was a gynecologist and ovariatomist in Lowell, Massachusetts. From 1851-1882 he performed over 300 ovariatomies with a mortality rate of about 25%, a relatively good showing for those days. He performed the first successful hysterectomy although this again was a case of mistaken diagnosis. The patient was opened because Burnham felt that she had an ovarian tumor. He did the procedure in June 1853 and reported it in *American Lancet* in 1854. The procedure was done under chloroform anesthesia. It was a supracervical hysterectomy and the patient survived. Despite his initial success, by 1883, Burnham reported only three successful operations in 15 tries and by that time he felt that the propriety of such as procedure was in doubt.

The first deliberately performed hysterectomy for fibroid tumors to be successful was completed by Gilman Kimball (1804-1892) also of Lowell, Massachusetts, on September 1, 1853. Kimball had studied under the previously mentioned Dupuytren in Paris. Chloroform was used for anesthesia. The uterus was delivered outside of the abdomen through an incision of approximately four inches in the midline. Ligatures were placed around the cervix and the uterus was cut above the cervical neck. Kimball described his procedure as "somewhat protracted, lasting nearly or quite forty minutes." The amount of blood loss was described as not exceeding four ounces.

Having thus performed vaginal as well as abdominal hysterectomies the gynecologic profession during the next 25 years practically abandoned these procedures because of the resultant high mortality and morbidity. During the quarter century between 1850 and 1875 little is recorded in the literature about these operations. Presented is mainly a condemnation of them such as the statement in 1872 by the Academy of Medicine in Paris, and by Hagar and Kaltenback in *Operative Gynakologie*, an influential text of the time.

Refinements of technique ● Beginning in the 1870s refinements of technique as well as the increasing use of anesthesia and antisepsis brought these procedures back into favor. One of these refinements was by Koeberle. He used the technique of placing double metallic sutures through the substance of the cervix and then exteriorizing these at the lower pole of the incision. These led to better hemostasis and a decreased incidense of infection. Another innovation was by Jules Pean who conceived the idea of removing the fibroid uterus by morcelation, i.e., cutting it into small fragments thus making it possible to remove large fibroid masses through the vagina.

Probably the most noteworthy refinements of technique were by W.A. Freund in January 1878. His procedure is remarkably similar to the one we use now for abdominal hysterectomy. He carefully prepared the vagina and the uterine cavity with a 10% solution of carbolic acid. He used anesthesia and antiseptic techniques. He made a midline incision. The intestines were lifted out of the pelvis wrapped in a carbonized towel and placed in the abdomen. A ligature was placed in the fundus of the uterus and the organ was lifted out of the abdominal cavity. Ligatures were passed through the tubes and ligaments and the bladder was separated from the fundus and the cervix. An opening was made into the vagina through the cul de sac and the uterus was severed from the uterosacral and cardinal ligaments. The Trendelenburg position was used.

At the same time as Freund was introducing these improvements, Czerny was further refining the vaginal procedure. He reintroduced the techniques of Recamier and paid particular attention to applying ligatures in the broad ligaments to decrease blood loss. Combining his improvements of Recamier's techniques, as well as using antisepsis and anesthesia, he increased the expected survival of this procedure.

In 1881 Freund made a further improvement in the technique of vaginal hysterectomy. After a series of experiments on cadavers, he concluded that

> ***The difficulties in the way of handling the broad ligaments suggested the thought of securing them in their continuity with suitable compression forceps, which could remain in place for a time. To prevent their slipping one blade is provided with a groove into which fits a convexity of the opposite blade. They are introduced from the vagina and clamped on the broad ligament at each side, lying close to and parallel to the uterus.***

Freund left these clamps in place for several days after the procedure. By introducing the compression forceps, Fruend essentially brought the procedure of abdominal and vaginal hysterectomy into the modern age.

With these new technical improvements, in addition to anesthesia and antisepsis, by 1886 the mortality of vaginal hysterectomy had dropped to 15%, with a further drop to approximately 10% by 1890. This was comparable to the mortality of the removal of a carcinomatous breast at that time. Conversely the mortality of abdominal hysterectomy still remained high, and as that procedure was performed mainly for cancer it was found wanting as it had little efficacy for a cure for that disease. In 1880 C.D. Palmer reporting at the meeting of the American Gynecological Society estimated that the mortality rate probably exceeded 70%.

During the 1890s leadership in gynecology as well as innovative medicine passed to the Johns Hopkins Medical School in Baltimore. Medical education there was based on science. The chair of gynecology was given to Howard Kelly. He had gone to medical school in Philadelphia but had postgraduate training in Germany. He further developed the surgical techniques of

hysterectomy as well as other pelvic surgery. The mortality of vaginal hysterectomy in his hands dropped to five percent. One of his most outstanding contributions was to introduce the practice of a residency training in gynecology.

During the same decade, many surgeons became disenchanted with the abdominal hysterectomy technique for the cure of cancer. In 1895 Emil Reis, one of Freund's students in Chicago, as well as John Clark, a resident under Kelly at Johns Hopkins, devised a technique of radical hysterectomy for invasive cervical cancer. Three years later Wertheim in Vienna started popularizing the same procedure, combining it with selective pelvic lymphadenectomy. His experience became so extensive that this procedure still bears his name. Some limited success was achieved with this technique but with a relatively high mortality rate as well as a high incidence of fistula formation.

In 1898 Pierre and Marie Curie discovered radium. This element was first put to medical use by Danlos in Paris and was introduced in America in 1903 by Robert Abbe in New York. It was popularized for gynecologic use by Howard Kelly, extolling its potential virtues in his text *Medical Gynecology* in 1908. By 1913 Abbe reported his experience in over 180 cancers, claiming some cures and many palliations in cervical disease. The success of radium and the morbidity of the Wertheim operation caused the abandonment of the latter. By 1950 radiotherapists were claiming that "the results of the radiotherapy of cancer of the cervix are the best results obtained for any treatment of a major form of cancer."

In the 1890s Schuchardt performed a radical vaginal hysterectomy, and his technique was further developed by Schaouta and reported on in 1908. The Schaouta technique, though accepted in Europe, never achieved popularity in the United States.

By 1910 the mortality from vaginal hysterectomy had dropped to approximately two and one half percent. By 1914 the Mayo Clinic advised that vaginal hysterectomy should be part of a cystocele repair, thus indicating that the mortality from this procedure had dropped so significantly that it could be performed for other than strictly uterine indications.

By 1930, after further refinement of technique by E.H. Richardson and others, the mortality rate for total abdominal hysterectomy had dropped to three percent. With mortality rates of three percent for abdominal and two and one half percent for vaginal hysterectomy, a limit was reached whereby improved techniques alone, such as close attention to ligature of vessels, use of compression forceps, anesthesia, antisepsis and hemostasis, could prevent mortality. Further improvement would result from the innovations of fluid therapy, blood banking, intravenous therapy, and most importantly antibiotics.

With these new improvements, J. Vincent Meigs in the 1940s ushered in the modern era of radical pelvic surgery by refining the technique of Bonney, who had been surgically active during the era of radiation therapy.

The increasing safety of the abdominal procedures made total hysterectomy more popular than the previously preferred supracervical procedure. In 1946, 69% of procedures were subtotal. By 1955, 99.5% of all hysterectomies were total.

By 1985 with the use of antibiotics and fluid and blood replacement the mortality rate for hysterectomy had dropped to 1/1000.

Thus during the last 100 years, the focus of the profession on these operations has shifted dramatically. In the 1870s these procedures had been abandoned as physicians felt them to be dangerous and unindicated. By the 1980s hysterectomy has become the second most commonly performed operation in the United States exceeded only by cesarean section, and approximately one out of every two women by the age of 70 have undergone this procedure. Once more the profession is reexamining the use of this procedure and trying to redefine the indications for hysterectomy in the approaching 21st century.

Bibliography

Graham, H. Eternal Eve, The History of Gynaecology and Obstetrics, Doubleday, Garden City N.Y., 1951

Hall, R.B. Some of the Sequelae Following Supra Vaginal Hysterectomy, Transactions of the American Association of Obstetricians and Gynecologists, 10:128, 1897

Kennedy, W. and Campbell, A. Vaginal Hysterectomy, F.A. Davis, 1944, Philadelphia.

Mathieu, A. The History of Hysterectomy, Western J. Surg., Obstet. Gynec. 42:1, 1934

Montgomery, E.E. Vaginal Hysterectomy, Transactions of the American Association of Obstetricians and Gynecologists 2:140, 1889

Ricci, J.V. One Hundred Years of Gynaecology 1800-1900, The Blakiston Company, 1951, Philadelphia

Ricci, J.V. The Development of Gynaecological Surgery and Instruments, The Blakiston Company, 1949, Philadelphia.

Ricci, J.V. The Geneology of Gynaecology, The Blakiston Company, 1950, Philadelphia.

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Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

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Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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References: 1. Data on file, CIBA Pharmaceutical Company. **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride. Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics; (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml; (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets—600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)

Bottles of 100	NDC 0083-0165-30
Bottles of 1000	NDC 0083-0165-40
Consumer Pack—One Unit	
12 Bottles—100 tablets each	NDC 0083-0165-65
Accu-Pak® Unit Dose (Blister pack)	
Box of 100 (strips of 10)	NDC 0083-0165-32

Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

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CIBA Pharmaceutical Company
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Summit, New Jersey 07901

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INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socioeconomics, governmental, and legal issues as related to medicine.

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When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

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CHORIONIC VILLUS SAMPLING:

An update from The Genetics Institute of Florida

Encouraging new data indicate that the risk factor for the first trimester prenatal diagnostic technique Chorionic Villus Sampling, is less than previously thought.

A recent study by Laird Jackson, M.D., director of the Department of Medical Genetics at Thomas Jefferson University in Philadelphia and an associate of the Genetics Insitute of Florida, indicates that the procedure-related loss rate associated with CVS, which is performed in the ninth to eleventh week of pregnancy, is approximately one percent when adjusted for the gestational age of the fetus. This compares favorably to the loss rate experienced with amniocentesis.

Other important facts about CVS include:

- Hundreds of congenital diseases can now be detected with CVS.
- Over 35,000 procedures have been performed worldwide.
- In addition to performing early amnios from 13.5 weeks on, the Genetics Institute of Florida has now performed hundreds of CVS procedures. Rapid results are available.
- Directors Jay Trabin, M.D. and Gene Manko, M.D., completed an intensive training program with Dr. Laird Jackson prior to opening the Institute.
- Genetics Institute is the first and most comprehensive private genetics counseling and prenatal diagnostics facility in the Southeastern United States.
- Genetics Institute performs comprehensive genetics counseling as well as Level II Ultrasound

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West Palm Beach, Florida 33401
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Joseph Schulman, M.D., Geneticist
Ron Wapner, M.D., Perinatologist

Mandatory Assignment: *A Band-Aid Solution*

As government deficits continue to soar and the Medicare program to grow, emphasis will be placed on controlling Medicare expenditures through Congress and regulations established by the Health Care Financing Administration (HCFA). Throughout the Medicare program's history, there has been some type of mechanism placed on physician charges in order to control health care expenditures.

This article includes an historical perspective of physician reimbursement under Medicare, a major overview of the current status on mandatory assignment, statistics of participating and nonparticipating doctors in the Medicare program as well as an overview of Medicare Part "A" and Medicare Part "B" expenditures in Florida for the past five years. In order to effectively educate the consumer about Medicare reimbursement, it is essential to be able to differentiate between what the physician charges for a designated service and what Medicare allows for that same procedure. Finally, this article discusses the various alternatives that are available to improve the existing Medicare program in lieu of trying to establish Band-Aid solutions such as mandatory assignment to ensure accessibility and affordability of quality health care services for Florida's senior citizens.

Historical perspective of physician reimbursement ● During 1969 the prevailing charge was lowered from the 90th to the 83rd percentile of customary charges and subsequently lowered to the 75th in 1970. Physicians' customaries were based on their median charges during 1970. Price and wage controls were placed on all Medicare charges as a result of the Nixon administration's price and wage control from 1971-1974. The Medicare Economic Index was established in 1972 and used to control annual increases in prevailing charges. The passage of the Deficit Reduction Act of 1984 created the participating and nonparticipating program for physicians.

Charge levels were frozen for physician services from June 30, 1984 to September 30, 1985. Nonparticipating physicians did not receive a fee increase over this 15 month period. The customary and prevailing charge for nonparticipating physicians was extended from September 30, 1985 through March 15, 1986 as a direct result of the Consolidated Omnibus Budget Reconciliation Act (COBRA), then through December 31, 1986. On May 1, 1986 the fee freeze for participating physicians ended, resulting in a 4.15% increase in prevailing charges.

As a result of the Omnibus Budget Reconciliation Act of 1986 (OBRA), participating and nonparticipating physicians received a 3.2% increase in Medicare prevailing charge levels beginning January 1, 1987. Charge levels for nonparticipating doctors were set at 96% of the prevailing charge levels for participating doctors. Also, during this year, Congress introduced the maximum allowable actual charges (MAACs), which has proven to be one of the biggest administrative headaches ever implemented by HCFA. Physician charges were not only limited by MAACs but specific designated charge reductions were made for cataract and anesthesiology services. A complicated formula has been established to go through 1990 for establishing future MAACs for nonparticipating doctors. Current prevailing charges are, in fact, based on 1972 charges. Increases in the prevailing charge are still limited by the Medicare Economic Index.

During the 1987 legislative session, 16 states considered some type of mandatory assignment legislation. In these states, nine bills were defeated, two states passed compromise bills (Oregon and Connecticut), and two passed mandated assignment (Rhode Island and Vermont). The state of Washington placed the issue on the ballot which was handily defeated in the fall of 1987. Massachusetts was the first state to pass mandatory assignment legislation. The Massachusetts law states as a condition of granting or renewing a physician's certificate of registration that the physician who, if he agrees to treat a beneficiary of health insurance under title XVIII of the Social Security Act, shall also agree not to charge to

or collect from each beneficiary any amount in excess of the reasonable charge for that service as determined by the United State Secretary of Health and Human Services. The Massachusetts law does not base assignment on any type of means test.

The state of Vermont passed legislation prohibiting physicians from charging or collecting from a Medicare beneficiary any amount in excess of Medicare's reasonable charge. There are, however, some exemptions to this law. The Vermont statute does not tie compliance to medical licensure. If a physician is found to have balance billed his/her patient, then they are required, by law, to make restitution for any of the monies received as a result of the prohibited balance billing.

During 1987 Rhode Island passed mandatory assignment legislation that established an eligibility income of $12,000 for individuals and $15,000 for a married couple.

The state of Connecticut passed a voluntary mandatory assignment program in 1987. This voluntary program would become mandatory if the medical society did not meet the law's requirements for the percentages of Medicare claims that must be processed on an assigned basis as well as a designated number of physicians willing to participate on a voluntary basis. In 1988, the voluntary program in Connecticut became mandatory because these stipulations were not met. However, the new mandated assignment law required physicians to accept an assignment for those individuals with an annual income of less than $19,950 and $24,000 for married couples.

The legislation that passed in Oregon requires physicians to post their participation status in the Medicare program. The notice basically states what the physician can and cannot charge based on participating status.

During 1988, 16 states considered some type of mandatory legislation. California, Colorado, Iowa, Indiana, Maine, Maryland, Minnesota, Rhode Island, South Carolina, and Wyoming defeated mandatory assignment proposals. Bills introduced in Florida, New Jersey, New York, Ohio, and Pennsylvania have followed the Massachusetts law prohibiting balanced billing making Medicare participation a condition of licensure.

Florida introduced a mandatory assignment bill in April which prohibited balance billing. Violation of this law would constitute grounds for disciplinary action. In addition, another pre-filed bill would have amended the state's Medical Practice Act to require doctors first licensed to practice in the state of Florida on or after October 1, 1988, to accept and treat all Medicare and Medicaid patients.

During a special session of the Legislature, the Florida Trial Bar failed to attach a mandatory assignment provision to the successfully enacted professional liability reform legislation, the Medical Injury Reform Act. In an effort to defeat proposed mandatory assignment legislation, the Florida Medical Association was successful in seeking the passage of a study bill. This bill created the Florida Task Force on Elderly Access to Health Care. The task force is to prepare a report to be submitted to the Legislature by March 1, 1989 with policy recommendations for improving access to health care for the state's elderly citizens and the steps required by the Legislature and executive branches of the government to implement these recommendations. The task force is to:

1. Evaluate the problems associated with the ability of the elderly to access and receive appropriate health care,
2. Evaluate the impact of a legislatively mandated prohibition on balance billing on access to medical services by Medicare recipients,
3. Appraise existing federal, state and local laws relating to health care for the elderly, and recommend modifications which require governmental involvement to assure meaningful access,
4. Evaluate methods for increased involvement by physicians and other health care professionals,
5. Establish strategies to increase involvement of medical schools in creating health care professionals who are trained in geriatrics, and
6. Evaluate proposals and recommendations to the Florida Congressional Delegation for changes in the federal laws and policies which would best assist Florida's elderly and medical community.

Putting the Medicare program into perspective ● According to a report prepared by the fiscal intermediary for Medicare, Blue Cross and Blue Shield of Florida, Inc., the number of beneficiaries in Florida has increased from 1.8 million in 1983 to 2.1 million in 1987.[1] The assignment rates in Florida as a percentage of claims in dollars paid out on assignment rates since Medicare enacted the participation program have increased from 42.4% in 1981 to 66.4% in 1987. The number of doctors who have signed participation agreements from the inception of the participating program has increased from 5,954 in 1986 to 10,882 in 1988.[2] During the past four quarters, reasonable charge reduction has amounted to a low of 22.9% in 1987 to a high of 24.7% in the first quarter of 1988.

Medicare Part "B" benefit dollars have increased from $495.9 million in 1980 to over $2 billion in 1987. In 1987 alone the total administrative expense and benefit dollars paid out for both Medicare Part "A" and "B" exceeded $4.5 billion.[3]

In discussing the current reduction in Medicare expenditures, one must look at the historical effect the prospective payment system has had on physician charges under Medicare. In 1982 the distribution of Medicare allowed physician charges in an inpatient setting amounted to about 60.8% of total charges compared to 49.7% inpatient physicians charges in 1985. While at the same time, the outpatient Medicare

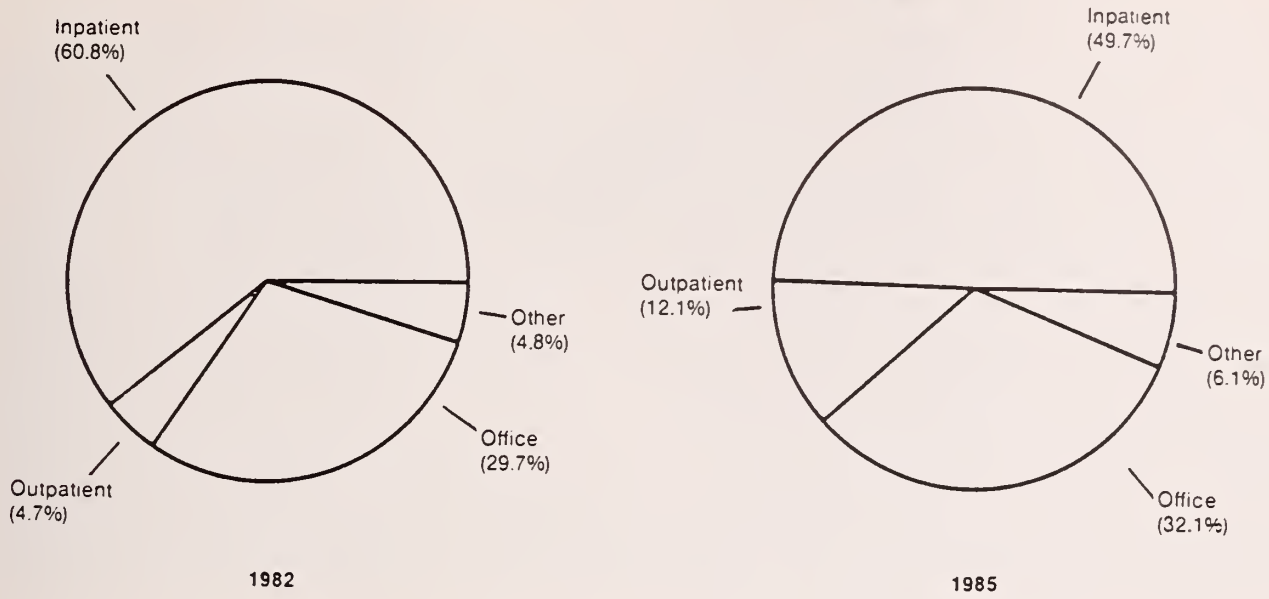


Fig. 1.—Distribution of Medicare allowed physician charges, by place of service: 1982 and 1985.
Source: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Information Analysis.

allowed charges in 1982 increased from 4.7% of the total charges paid to 12.1 % in 1985.[4] The amount of office charges increased slightly from 29.7% in 1982 to 32.1% in 1985 (Fig. 1). Inpatient surgical charges have declined from 81.9% in 1982 to 62.8% in 1985 while outpatient surgical procedures have increased from 4.7% to 19.9% during the same time period.[5] This clearly shows an indication of more services being provided in an outpatient or office setting as opposed to the traditional hospital setting.

Medicare income ● According to a survey conducted by the American Medical Association, Socioeconomic Monitoring Department, the amount of income per hour showed a 54 cents decrease for every percentage point increase in Medicare patient load.[6] The survey also indicated that a $1.35 increase in hourly income was associated with a .45 percentage point decrease in Medicare patient load. There is a perception that physicians are paid by Medicare in full. The physician's actual charge is discounted from 10% to 30% based on the amount of the charge that Medicare recognizes as reasonable. In fact, actual payments by Medicare are substantially below normally submitted charges as recognized by other third-party payors. These facts are essential in the battle against mandating assignment and in advocating the need for major reform of the Medicare program (Tables 1 and 2).

The amount paid by Medicare as a percentage of

Table 1.—Payment for Selected Procedures as a Percentage of Submitted Charges, by Medicare.

Procedure	Average Submitted Charge	Medicare
Est. Patient Office Visit	$ 30	73
New Patient Office Visit	63	70
Mastectomy	609	59
Total Hip Replacement	2,900	72
Coronary Artery Bypass Graft	4,144	77
Cholecystectomy	1,008	69
Hernia Repairs	689	69
Transurethal Resection of Prostate	1,362	73
D & C of Cervical Stump	362	59
Total Hysterectomy	1,341	63
Cataract Extraction	1,872	79

Source: Socioeconomic Monitoring System and Health Care Financing Part B.

Table 2.—Payment for Established Patient Office Visits as a Percentage of Current Usual Fee, by Geographic Location, Specialty Class and Payor Type.

	Current Usual Fee	Charge Paid by Payor Type as % of Current Usual Fee				Other Private Insurance
		Medicare	Medicaid	PPO	IPA	
Census Region						
Northeast	$34.2	73%	39%	77%	80%	86%
North Central	24.9	74	53	90	86	91
South	28.4	72	50	94	85	94
West	32.9	72	49	83	81	94
Physician Specialty						
General/ Family Practice	23.1	77	60	97	97	100
Medical	30.8	74	45	84	76	91
Surgical	32.0	71	45	84	83	90
Rural-Urban Location						
Rural	23.4	72	57	94	89	93
Urban	31.5	74	45	83	80	92

Source: Socioeconomic Monitoring System, American Medical Association.

the total usual fee ranges anywhere from 71% to 77% of the actual charge submitted. Currently, physicians accept assignment for almost 3/4 of all Medicare claims with the cost to beneficiaries of the extra billing on nonassignment claims reaching $2.5 billion in 1987.[7]

Medicare's impact on the health care system ● In order to understand the impact Medicare has on Florida's health care system, one must take into consideration the Medicare population in this state. Nationally, the Medicare eligibles (65 years and older) account for 12% of the population. In Florida 17.3% of the population was aged 65 and over in 1980. It is predicted that the Medicare population will be well over 20% in the year 1990 and over 26% by the year 2020 in Florida.[8]

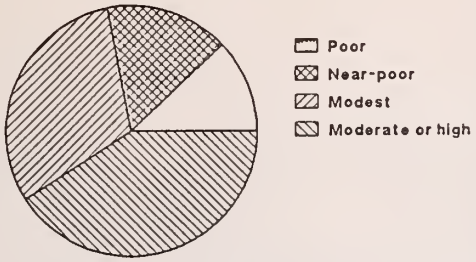
The declining birth rates and increasing number of the elderly population will place a major hardship on the working population to finance programs for the elderly.[9] Twenty-three percent of the 28.5 million Americans over 65 years of age are frail and in need of long-term care services.[10] In fact, the population aged 85 and older is increasing faster than any other age group and will require more frequent, more acute care services.

According to a study conducted by the Physician Payment Review Commission, "In 1986 persons aged 85 and older will merely twice as likely to be poor as those between the ages of 65 and 74. The economic well being of the elderly varies considerably by race and sex, with women in minorities being particularly vulnerable. (Fig. 2)"[11]

According to a U.S. Senate Special Committee on Aging, the poverty rate for the elderly has declined more than 29% since 1967 to 12% in 1987. From 1975 to 1985, a ten year period, services utilized per enrollee per year have doubled (Fig. 3).

Participation rates ● The current national Medicare participation rate has grown from 42.4% in 1986 to 45.4% in 1987, according to the AMA Socioeconomic Monitoring Report. In 1987 participation rates ranged from 33.7% for anesthesiologists up to 60% for pathologists.[12] The greatest participation increase was for specialists covered in general/family practice, internal medicine, surgical specialties, obstetrics/gynecology, radiology, and anesthesiology (Table 3). Physicians operating in urban areas had a participation rate of 48.3% while those practicing in rural areas had 39.4% with a 45.1% rate across the board. In 1987 the percentage of services assigned by nonparticipating physicians with Medicare patients ranged from 17.3% for family practice to 32.7% for psychiatry (Fig. 4). Nonparticipating physicians services devoted to Medicare patients accounted for 23.6% of total services. Eighty-six percent of all physicians assigned at least one of their claims in 1987. The percentage of nonparticipating physicians who accept assignment on 100% of their Medicare claims amounted to 4.5% in 1987.[13]

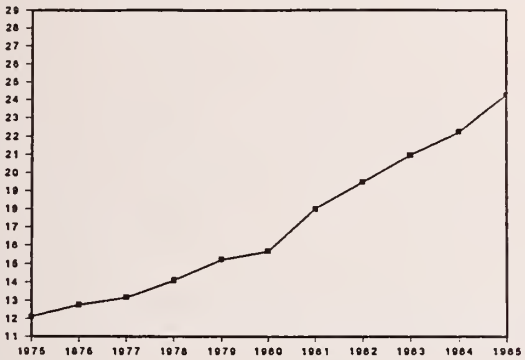
Preliminary statistics prepared by the Health Care Financing Administration indicated an assignment rate of 73.4% for all Medicare claims. Approximately 75.4% of all charges submitted to Medicare were, in fact, on assignment (Table 4). In Florida the assignment rate has grown from a low of 61.7% in 1987 to a high of 76% for all Medicare claims in June, 1988



Poor = Less than 100% of the poverty level
Near-poor = 100%-149% of the poverty level
Modest = 150%-299% of the poverty level
Moderate or High = 300% of the poverty level or higher

Source: The Commonwealth Fund Commission on Elderly People Living Alone.

Fig. 2.—Income distribution of the elderly, 1987.



Source: Health Care Financing Administration, Medicare Part B Summary Data.

Services are gross counts of approved billed services.

Fig. 3.—Total Part B services per enrollee, 1975-85.

(Fig. 5). These statistics clearly illustrate that nonparticipating physicians are accepting assignment on a claim-by-claim basis recognizing the individual financial needs of their patients without the need for government intervention.

The decision whether to participate in the Medicare program ● Many physicians do accept assignment on a case-by-case basis and do not wish to bow to the government's demands by accepting what they recognize as the government's "reasonable charge" as payment in full. However, in Florida, physicians who have a greater Medicare population base do tend to have a higher participation rate. Probably the most significant factor that influences physicians to participate in the Medicare program other than financial

Table 3.—Assignment Rate for All Medicare Physicians by Specialty and Assignment Rate Category, 1987.

	Percent					
	0	1-24	25-46	50-74	75-99	100
All Physicians	14.0	21.1	7.8	5.8	3.4	47.9
Specialty						
General/ Family Practice	18.1	27.5	5.8	3.7	1.4	43.5
Internal Medicine	10.6	23.6	8.7	5.7	3.3	48.1
Surgical Specialties	9.7	22.5	10.1	8.3	5.0	44.4
Pediatrics	26.1	5.1	0.0	2.8	0.0	66.0
Obstetrics/ Gynecology	18.4	15.8	3.9	4.1	7.0	50.9
Radiology	15.2	14.4	4.9	2.4	1.2	62.0
Psychiatry	26.1	7.1	6.8	7.7	4.3	48.1
Anesthesiology	13.8	22.2	17.0	9.4	2.9	34.8
Pathology	16.7	16.2	2.4	1.2	1.6	62.0
Other Specialties	15.2	14.4	4.8	4.8	2.6	58.3

Source: AMA's Socioeconomic Monitoring System, 1987 core surveys of nonfederal patient care physicians, excluding residents.

All Physicians	**24.0%** **23.6%**
Specialty	
General/ Family Practice	18.6 17.3
Internal Medicine	24.4 23.1
Surgical Specialties	28.5 27.1
Pediatrics	3.5 15.0
Obstetrics/ Gynecology	32.5 25.3
Radiology	12.4 18.7
Psychiatry	29.4 32.7
Anesthesiology	24.0 25.6
Pathology	13.4 18.9
Other Specialties	23.0 25.2
1986 1987	

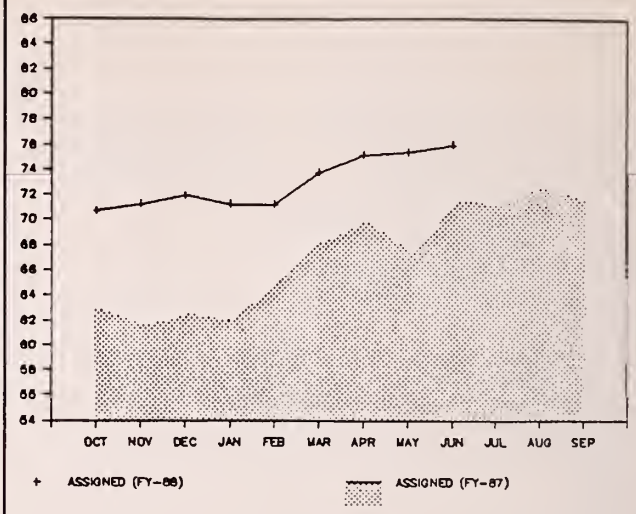
Fig. 4—Percent of services assigned by nonparticipating physicians with Medicare patients, 1986 and 1987.

Source: AMA's Socioeconomic Monitoring System 1986-87 core of surveys of nonfederal patient care physicians, excluding residents.

Table 4.—National Assignment Rates for Total Part B Services, 1973-87.

Calendar Year	Assignment Rate (In Percent) Claims	Charges
1973	56.9	49.7
1974	56.0	49.1
1975	55.9	49.0
1976	54.4	48.9
1977	54.0	49.6
1978	53.7	50.9
1979	54.0	51.9
1980	54.2	52.9
1981	54.9	54.2
1982	54.4	55.4
1983	55.8	56.5
1984	59.2	59.7
1985	68.5	68.6
1986	68.0	69.6
1987 (prelim.)	73.4	75.4

Sources: HCFA, Medicare Participating Physician/Supplier Claims Workloads Reports and Reasonble Charge and Denial Reports.



ASSIGNMENT RATE (FY-88)

MONTH	FY - 88 ASSIGNED	FY - 88 UNASSIGNED	FY - 87 ASSIGNED	FY - 87 UNASSIGNED
OCT	70.7	29.3	62.7	37.3
NOV	71.2	29.8	61.6	38.4
DEC	71.9	28.1	62.3	37.7
JAN	71.2	28.8	61.8	38.2
FEB	71.2	28.8	64.7	35.3
MAR	73.8	26.2	68.1	31.9
APR	75.2	24.8	69.7	30.3
MAY	75.4	24.6	67.3	32.7
JUN	76.0	24.0	71.4	28.6
JUL			71.2	28.8
AUG			72.4	27.6
SEP			71.5	28.5

Fig. 5.—Assignment rate.

reasons is the added Medicare regulations that nonparticipating physicians must adhere to. Additional paperwork and the time consuming process of following all the rules and regulations for nonparticipating physicians can become a very costly and timely process which often results in claims being tied up for months that require additional information or correction. Added requirements for nonparticipating include the MAACs, prenotification requirements for nonassigned elective surgery of more than $500, and regulations that prohibit collection of fees from beneficiaries in cases of nonassigned services determined to be medically unnecessary. It is for these reasons that physicians do feel forced into participating in the Medicare program. As the percent of participating physicians has significantly increased from 1984 to 1986, the amount of additional revenues derived from Medicare patients as a percentage of the total patient base has virtually remained unchanged over this same time period.[14]

Even with the increased number of physicians participating in the program as well as a large percentage of claims and dollars paid on assignment in Florida, there is still pressure from various interest groups for mandatory assignment.

AARP position ● The American Association of Retired Persons (AARP) at its 1988 annual meeting initiated several resolutions that placed major emphasis on the federal government to cut spending and to eliminate the deficit by increasing revenues through taxation. At the same time, the members wished to increase access to health care through additional appropriations for Medicare services and the passage of legislation to assure accessibility and affordability of quality health care. This seems quite ironic considering the fact that while the federal government continues to cut the Medicare budget and places the responsibility of financing the program on hospitals and physicians, AARP still pushes for mandatory assignment. In fact, the members not only support increasing assignment rates but they wish to reduce beneficiary liability for unassigned claims and place a ceiling on physician charges for unassigned claims and development of various incentives to ensure that physicians will accept assignment regardless of how much they are reimbursed. In one of the studies conducted for the AARP, Florida has been targeted as a "green light" state where it has been demonstrated that a mandatory assignment requirement would not jeopardize the elderly's access of health care.

The medical communities' responsibility ● It is the physicians and medical communities' responsibility in Florida to take the role in educating various interest groups including AARP and the Legislature on the negative aspects of mandatory Medicare assignment. The increased out-of-pocket expenses to beneficiaries

has come about as a result of the federal government increasing mandated deductibles and copayments and as a result of decisions by Congress and the administration to reduce federal outlays in the Medicare program. If Florida was to pass mandatory assignment legislation, it would encourage younger physicians to move to states that do not have mandatory assignment and older physicians to cease practicing medicine. Florida, being one of the largest populated states in the nation and a fast growing Medicare population, would significantly suffer from the establishment of mandatory assignment law.

Multiple health care needs of the elderly ● The health care needs of the elderly are multiple and require a combination of acute and long-term care clearly indicating the need for proper and adequate levels of financing by the federal government for Medicare. It should and must not be the responsibility of physicians to continue to subsidize the Medicare program. Continuing to place a cap on services will ultimately affect the quality of care provided to Medicare beneficiaries.

Physician price controls ● William J. Baumol, Ph.D., an economist, stated that "price controls is a solution which would inflict a very heavy cost in loss of welfare upon the very person whose interest such a program would be designed to protect."[15] Dr. Baumol goes on to state that "price control measures are worse than any attempt to cure disease by legislative or regulatory fiat because the latter would simply have no effect at all while price controls have side effects which are serious and which often exacerbate the problems that they are intended to alleviate."[16]

Mandatory assignment is not the answer to ensure affordability and accessibility to quality health care services for our elderly. Quick-fix solutions that Congress and state Legislatures are trying to apply to the Medicare program will only solve the problem for a short time and exacerbate the long-term solution. Physician fees have, in fact, been under some type of controls since the early 1970s. Congress will continue to attempt to protect the Medicare program by initiating supposedly cost-saving programs such as capitation.

Medicare reform ● The AMA supports a program that would be an indemnity based physician reimbursement system. An indemnity based system would provide predictability of Medicare payment and expenditures, would eliminate distortions in relative payments that are inequitable to patients and physicians, and will ensure the continuation of freedom of choice by patients of their physician. There are about four workers paying taxes to support services required by two Medicare beneficiaries and by the year 2000 it is expected that there will only be two workers to support each Medicare beneficiary.[17]

The AMA's proposal would replace the existing Medicare program with a system of vouchers. These vouchers would allow older persons to purchase health insurance with comprehensive benefits including catastrophic protection. The vouchers would be financed based on an adjusted income during the beneficiary's working years and by continuation of the employer health insurance payroll tax.

The Physician Payment Review Commission created by Congress is diligently working on how physicians should be reimbursed. Currently, they are waiting on the study being developed by Harvard University entitled *The National Study of Resource Based Relative Value Scales for Physician Services*. This study will play an intricate role in determining how physicians will be reimbursed by the Medicare program in the future. The AMA believes it is a more effective alternative to physician DRGs and overall capitation rate for physician services, but whether it will be widely accepted remains to be seen.

Conclusion ● Clearly, mandatory assignment will not ensure affordability and accessibility of quality health care. Capitating medical costs will eventually impact on the quality of care that is rendered.

John F. Holahan, editor of the *Medicare Physician Payment Reform*, states, "Balance billing is desirable as a method of assuring a high level of access to physicians, for providing safety valves for physicians when fees are controlled, and for recognizing legitimate intra-physician differences in quality. Policies that limit growth and fees to control expenditures can severely affect access to certain physicians unless balanced billing is permitted. However, permitting balance billing while at the same time limiting fee growth in response to volume increase could reduce access for the poor and chronically ill."[18]

Short-step remedies will not eliminate the problems with the Medicare program. In order to develop a system that assures equitable reimbursement and provides freedom of choice and accessibility of care for all senior citizens, a major reform of the Medicare program is required based on an indemnity physician reimbursement system.

References

1. Blue Cross and Blue Shielf of Florida, Inc., Fiscal Intermediary for Medicare, Medicare Part "B".
2. Ibid
3. Ibid
4. Fisher, C.R.: Impact of Prospective Payment System on Physician Charges Under Medicare, Health Care Financing Trends, Summer 1987, p. 101.
5. Ibid
6. Socioeconomic Monitoring System Report (AMA Center for Health Policy Research, 1988), Volume 2, No. 1, January, p. 1.
7. Annual Report to Congress, Physician Payment Review Commission, March 31, 1988, p. XIII.
8. Shoemyen, A.H. and Floyd, S.S.: 1987 Florida Statistical Abstract, University Presses of Florida, 1987, pp. 20-21.
9. Fact Sheet on Aging Issues, Department of Health Care Delivery, Division of Health Policy and Program Evaluation, American Medical Association, January 1988.
10. Ibid
11. Annual Report to Congress, Physician Payment Review Commission, March 31, 1988, p. 26.
12. Socioeconomic Monitoring System Report, AMA Center for Health Policy Research,

1988, Volume 2, No. 4, July, 1988, p. 1.
13. Ibid, p. 3.
14 Cotter, P.S.: Physician Involvement with Medicare, 1984 and 1986, Socioeconomic Characteristics of Medical Practice, 1987, p. 11.
15. Baumol, W.J.: Price Controls for Medical Services and Medical Needs of Nation's Elderly, New York University, p. 7.
16. Ibid, p. 4.
17. Protecting the Elderly A New Approach to Financing Health Care and Preserving Access to High Quality Health Care, American Medical Association, p. 3.
18. Holahan, J.F. and Etheredge, L.M.: Medicare Physician Payment Reform, Urban Industries Press, Washington D.C., pp. 172-173.

Robert W. Seligson, M.B.A.
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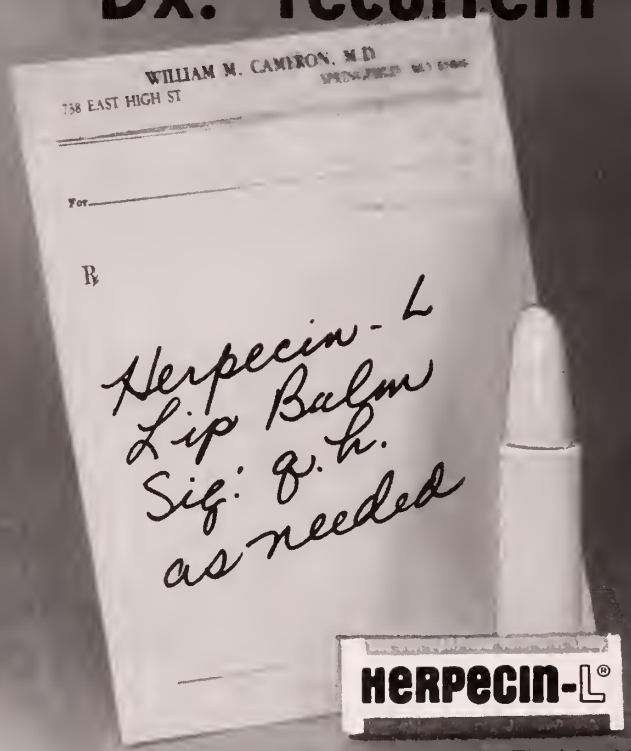

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Inaugural Address of the President

I feel privileged to join the ranks of 142 predecessors who have had the opportunity to serve as President of the American Medical Association. As I stand here — humbly, respectfully and enthusiastically accepting the challenges of this office — I am honored to be in the presence of this audience, the leaders of American medicine.

Pivotal time ● This opportunity is especially meaningful to me because it comes at a time when our profession is at a zenith of unprecedented accomplishments. Working with the people of this country, we have achieved so much. Life expectancy continues to lengthen. The quality of life continues to improve. And the public now exhibits a widespread and impressive commitment to self-care and the prevention of illness. The advances of many decades are manifest in the decline in the incidence of heart attacks and strokes, in the long and productive lives many people lead for years after a cancer diagnosis, and in the fact that infections — except for AIDS — are better controlled than ever before. And yet, there is much that both the medical profession and the American people still need to do.

We must get a handle on the high cost of health care. We must find solutions to the drug crisis and other frightening conditions that plague so many American adolescents. We must develop ways to reach out and care for the medically indigent. We must solve the problems of providing adequate physical and mental health services and long-term out-of-hospital care for the elderly. Indeed, we must strive to assure that every single American has access to proper and affordable care whenever and wherever it is needed.

This is a serious agenda of serious problems. And if we are serious about attacking them, all Americans must give not only attention but also active participation to this agenda.

This evening, I want to speak directly to this distinguished audience, and also to reach out to every physician in this country, and to the American public as well. I want to get my message across to both physicians and the general public because I believe this is a pivotal time — a pivotal time in the relationship between doctors and the people we serve.

It used to be that everybody understood medicine was the doctor and the patient. Artists have depicted the doctor-patient relationship beautifully over the years. I remember, and I'm sure many of you remember, that Norman Rockwell in the 1950s had a cover on the *Saturday Evening Post* that showed the doctor and the patient in the examining room, scales in the corner and diplomas on the wall. A middle-aged physician is fixing a hypodermic for his young patient, a small boy standing on a chair with his rear end exposed, waiting for the shot he knows he has to have. Everyone who has ever seen that picture can relate to the way the little boy's apprehensive scowl is tempered by an admiring look of great trust and faith, because this young man knew that there was a bond between him and his doctor.

A lot has changed since Norman Rockwell painted this picture, and if Mr. Rockwell were alive and painting today — if he were painting the canvas of medicine in the 1980s and 1990s — he would have to divide the doctor and the little boy by hospital administrators, insurance company executives, federal regulators, state and national legislators, and even the doctor's own peers looking over his shoulder. Like it or not, it is clear that all of these are going to remain in the picture in one form or another. We cannot return to a bygone era, and we certainly would not want to give up modern medical advances, even though we might sometimes wish for a simpler world. Yet we must preserve the special doctor-patient bond — that special trust and faith. We must connect physicians with patients in the public's mind just as closely, just as indelibly as Norman Rockwell did. I believe the key to doing this is service.

Service, a way of life ● Service has always been one of the hallmarks of our profession. Throughout history, physicians have been known for service to patients', institutions of medicine and healing, the community and to mankind. Physicians are still the most dedicated, the most serving, of all people. Our willingness to endure long, arduous periods of education and training, our role as the patient's advocate, our on-call and on-demand lifestyle, our charity — these all bespeak service. Recent data show that doctors are donating increasing amounts of care. In fact, in a recent survey of primary care physicians, 68% had volunteered their time at a free clinic, nursing home or other social service health care facility. One third of all care given by emergency physicians in this country is donated.

Often, organized medicine is the mechanism for contributed services. Already, two specialty societies and 11 state medical associations have instituted voluntary Medicare assignment programs. An equal number of state associations are considering such programs. As an example of another way we can serve those at, or below, the poverty level, a Kentucky Medical Association program that provides free care for the medically indigent has tapped more than half the physicians involved in active patient care.

So there is extensive evidence that physicians do serve and serve generously. But the public does not always perceive us as being charitable.

Yes, they respect us for learning. They appreciate our long hours of work. They regard with awe our ability to apply highly technical scientific information for their individual benefit. As a result of this perception of what doctors do for them, they have afforded us a special status in society, and rank us at the highest levels of trust and confidence.

Yet they are not sure why we serve. They wonder if we are altruistic for their benefit or hard-working primarily for our own?

For physicians, who have always held service as our highest goal, it is something of a shock that our motives are questioned. But it is a sign of the times. So we must accept it, and take it as a mandate to show clearly to the American people that our primary motive is, as it has always been, to serve them.

Service starts with patient contact. Some 4 million patient interactions every day give American doctors the opportunity to demonstrate not only competence but also genuine compassion — our caring and devotion to each individual patient we serve.

Service continues with our teaching. At least a third of us are already involved in medical education full-time or part-time, paid or volunteer. But all of us must extend our teaching to patients and the public.

We also serve through involvement. Physicians' talents, and those of our spouses, may lead to involvement in many areas. For instance, you may choose to lead a church youth group, work with scouts, or give time in the school library. You may decide to coach a Little League team or drive the elderly to the grocery store. You may want to initiate a recreational program in a nursing home, volunteer with Meals on Wheels, or visit shut-ins. You may want to be a museum docent, sing in a choral group, or play in your local symphony. Or you may choose to run for public office. For certainly there are opportunities at all levels of government.

Throughout the United States physicians and their spouses are serving their communities in the ways I have described and more. The point is we all must give of ourselves. We all must get out into the community. We all must let the public know we care.

In my home town, patients are always telling me what a wonderful thing it is for the medical profession that one of us — a local physician — is on the bench at every major athletic event where our high schools compete, that a physician's spouse serves as county commissioner, and another is a member of the school board. I am proud to say that my wife Margaret has also served Durham and its people in many ways, not as an elected official, but in activities ranging from teaching Sunday School, to setting up day care centers, to serving on the Durham Housing Authority. And she has been involved all the while with the Medical Auxiliary. Our Auxilians do so much for our profession that we cannot do for ourselves and I thank you all. Let me assure you that in addition to enhancing our professional image and helping others, service truly is its own reward.

Service, a mission in life ● In the years to come, the big issues — issues like Medicare, substance abuse, professional liability, AIDS, and rationing health care — are ultimately going to be decided in the public forum. When we have convinced the public that our mission in life truly is to serve them, we will have their support as these issues come up.

Dr. Edmund Pellegrino, who directs the Kennedy Institute of Ethics, recently observed, "How physicians resolve the inherent tensions between self-interest and altruism has always been a surer test of moral quality than the oaths they utter." Dr. Pellegrino is quite right.

But often, all it takes to resolve the tension between self-interest and altruism is a little peer pressure carefully applied. So if your colleagues back home say they are too busy to volunteer, take the time to ask them personally to get involved. Most of us do what we do not because we see an opening and move for it, or plan ten years ahead, but because somebody says, "Will you do this?"

That's how I got into organized medicine. When. a surgeon friend called and said, "I want you to be my vice speaker in the North Carolina Medical Society House of Delegates," I took the job. I did this with some fondness for the activity, but mostly for love of the man, and the opportunity to work with him. My life, and I guess most everybody's life, has been that sort of thing. We get involved in service because somebody asks us. We model ourselves after those we respect. And before we know it service is a way of life.

As I go around the country and talk with the people of America during the coming year, I will be sharing with them the service ethic in which medicine has always been quietly and nobly rooted. I will be reminding them that the American medical system is truly one of our country's greatest treasures. I will be urging them: concerning health, beware, be informed, be involved.

Beware of changes that make it difficult, even impossible, to protect the high quality care you expect and deserve. Be informed about what constitutes good health, and do what you can to help yourself and others to have good health. And be involved in insur-

ing that collectively we make the right political decisions now, and in the future.

For example, today's House of Delegates' action on Medicaid reform makes a solid statement of physicians' concern for the good of those least able to fight for their own medical needs. We have pledged our power and our prestige to help these needy people. But we also need the power of the American people to urge Congress to move quickly to enact Medicaid reform. And we need the people's involvement to keep working with us in the same cooperative spirit as we address other needs on the health care agenda.

Three challenges ● Finally, I make three challenges this evening. First, I challenge every physician in America, whether in practice, education, research, administration or any other endeavor — I ask every physician to tithe your time for the benefit of the American people. Just one tenth of the normal work week — four hours a week serving the public in the way you think is most helpful. Second, I challenge each American citizen to learn more about and work for even better health care in America. I am asking the public to help create a strong, informed constituency for health.

To catalyze both the physician and the public efforts, as my third challenge, I am asking every physician's organization in this country, at every level — county, state, and specialty — to organize and staff ombudsman offices. These offices will encourage every physician member to fulfill the service tithe. They will assist physicians in identifying work which is individually most meaningful. They will provide health care information to the public and referrals to physicians. They will receive the public's questions, concerns, suggestions, and recommendations about health matters, and follow through on consumer complaints. In order for these ombudsman offices truly to become a two-way liaison between physicians and the public, medical organizations can tap the growing ranks of retired or semiretired physicians. This is a group of highly qualified, highly competent, dedicated individuals who know how to get things done. Such ombudsman offices, staffed by retired physicians, will surely show our patients, our neighbors, and our community leadership that their health is our number one concern.

To demonstrate the significance of this proposal, I am pleased to announce this evening that the Board of Trustees of the American Medical Association has established a special award, President's Citation for Service to the Public, to honor medical associations and societies that excel in service. And I look forward to presenting the first award in December.

So this evening I urge the physicians of America: make service an avocation as well as a vocation, because service is something we must do so that patients know in no uncertain terms that doctors are men and women whose first motivation is public service. The days portrayed by Norman Rockwell may be gone forever but if all America's physicians will rededicate ourselves to serve each of our communities, we will bring into sharp focus a clear picture of why and how doctors serve each patient.

Last week just before I came to Chicago, an elderly patient of mine said, "Doctor Davis, I'm glad you're going to lead the AMA. You'll travel the country, you'll travel the world, but always let your office here know where you are, there may be something I'll want to ask you."

This evening, there is something I want to ask you — the physicians and the people of this country: Let's work together so quality health care will not only continue in America but will continue to improve.

James E. Davis, M.D.

Presented at the annual meeting of the Americal Medical Association in Chicago, June 29, 1988.

The Medical Record: Stand By It Or Fall By It

In its basic unadulterated form, the medical record is an objective recording of the patient's clinical course progressing from evaluation and diagnosis to treatment and response. The medical record reflects the physician's thoughts and management of the clinical problem. If it is not recorded, it was not thought or done. The medical record is the foundation of good medical practice. After all of the skilled emergency management, complex and difficult diagnostic studies and magnificent surgery, the clear, accurately recorded medical record is all that remains to confirm what was done or not done. This fundamental principle is learned by every student of medicine. Progress up the professional and scientific lad-

der seems to blur the focus on good, basic medical recordkeeping.

The practice of medicine has always been demanding, requiring the busy physician to face many crises simultaneously. These increasing pressures have encouraged some to take shortcuts, intentional and unintentional. The medical record, unfortunately, is one of the first to go with occasional disastrous consequences for the patient and doctor. The fallout is seen at each meeting of the Florida Board of Medicine (FBM) when physicians appear to defend inadequate and improper medical records. The Medical Practice Act, Chapter 458.331, FS, lists as a ground for disciplinary action, "the failure to keep written medical records justifying the course of treatment of the patient, including but not limited to, patient histories, examination results and test results." The following are examples of some of the common errors seen.

Late entry into the medical record ● The patient died. Following the patient's death, the widow obtained copies of the medical record. In response to a complaint, the Department of Professional Regulation (DPR) compared the widow's records with those provided by the doctor during a subsequent investigation and found that there had been at least two additions and alterations to the records. In addition, the patient's history and physical and discharge summary had not been dictated until a year after the patient's death.

At a hearing before the Division of Administrative Hearings, the Hearing Officer found the doctor guilty of four counts of violation of Chapter 458 and recommended that his license to practice medicine be placed on probation and he pay a fine of $5,000. The FBM increased the penalty; suspending his license to practice for one year and two years probation in addition to the fine.

Alteration of medical records is dishonest. If an addition or alteration of the medical record is done it must be annotated. The doctor must clearly indicate the change, sign and date the entry. JCAH and hospital bylaws require that a history and physical exam be on the chart within twenty-four to forty-eight hours of admission. A discharge summary is required to be completed within 30 days of discharge. If the medical record is altered at the time of dictating the discharge summary, all changes must be initialled and dated. It is important to realize that throughout the patient's hospitalization the medical record is frequently being copied in part or in total for a variety of interested parties. This can occur between a morning note and an evening progress note. Correction of the notes is acceptable but it must be annotated.

Changing an order on the Order Sheet after the nurse has taken it off ● The patient suddenly became very ill and died. During the course of management it became evident that an error had been made during recording of the initial orders. The patient had been receiving a dose of a drug that was five times that intended. The doctor responded by overwriting the initial dose numbers to make it appear that the correct dose had been ordered.

At his appearance before the FBM, the physician insisted that he had recognized his error and had changed the dose by writing over the initial numbers in a timely manner. Regardless of this, the patient received an excessive dose of a drug that contributed to medical complications. The doctor's license to practice medicine was suspended.

Writing physician's orders into the medical record is a complex event that sets into action a series of events involving many persons in addition to the initiating physician and nurse. Several nurses covering many shifts are involved in addition to the ward clerk and pharmacist. This makes it imperative that all orders are legible and clear. A change will become lost if it is not properly annotated. If an order is changed it must be crossed out and a new order written. Inform nursing of the change. It is a good idea to review all orders with the nurse to insure that all team members understand. Do not overwrite a previous order.

Incomplete and inaccurate surgical operative note ● During a routine abdominal surgical procedure and biopsy, the large bowel was accidentally perforated. No intraoperative, surgical consultation was requested although a frozen section indicated colon mucosa. Post operative consultations were obtained. The operative note did not record the biopsy which was an incidental part of the major procedure. The patient died of complications.

Action was taken against this physician's license for failure to keep adequate records justifying the care and "failing to practice medicine with that level of care, skill and treatment which is recognized by a reasonably prudent similar physician."

All medical records must be complete. As with all procedures performed on a daily basis, dictated operative notes tend to become routine. Unique and unusual aspects are sometimes overlooked and omitted in the speed of dictation. It is imperative that all changes, deviations, complications and unusual observations be recorded. The operative note is frequently the only source of information that will differentiate one case from another. This is true of all procedures including surgery, endoscopy and diagnostic injections. Dictating or writing a note is not enough. It must be complete and accurate. Clinical judgment cannot be legislated but basic, minimal medical practice standards can.

When in trouble ask for a consult. Stat.

Refusing to provide a copy of the medical record to the patient ● The patient requested a copy of his medical records from his physician. The doctor refus-

ed. The patient reported him to DPR. During an investigation, it became apparent that the doctor was also prescribing excessive and inappropriate amounts of a scheduled drug. He appeared before the Board to explain both violations. Action was taken against his license.

Chapter 455.241, FS, requires that "any licensed physician shall, upon request of a patient, furnish copies of all reports made during examination and treatment. The furnishing of these copies shall not be conditioned upon payment of a disputed fee for service." The Medical Practice Act, Chapter 458.331 (1) (g), FS, also finds grounds for disciplinary action "in failing to perform any statutory or legal obligation placed upon a licensed physician."

One of the consumer members of the Board, a lawyer, stated, at the end of a difficult three day meeting, "The best ally a physician has, when challenged, is a complete and accurate medical record." That says it all.

J. Darrell Shea, M.D.

Reprinted with permission from Central Florida Physician, Orange County Medical Society, June 1988.

WHY AMA?

The AMA has actively sought to attract women as members and leaders in organized medicine. Ongoing AMA projects and concentrated efforts by county, state, and specialty societies have significantly increased the leadership role and membership of women in organized medicine. Strengthening the voice of women in medicine through encouraging active participation: it's one more good reason why you should be a part of the AMA.

To Join,
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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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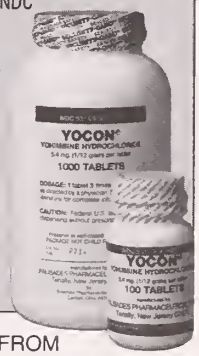

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Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

Auxilians Bring Home the Bacon In '87 - '88

Ready, willing and able auxilians are bringing to a close a year that has been unorthodox in the legislative function of the FMA Auxiliary. Prior years have had these members busy keeping abreast of legislation affecting medicine and working to educate legislators as to the position taken by the FMA on the various issues. The thrust of this usually began around the end of February and came to an end the first week in June.

As early as last summer, the petition drive was announced to get a constitutional amendment on the November 1988 ballot to allow voters to decide the desirability of a $100,000 cap on noneconomic damages in liability awards. The Auxiliary was given the task of obtaining the signatures of qualified voters in order to realize the goal. Then FMA-A President Susan Marks was asked to chair the endeavor.

There being no rest for the weary, auxilians accepted the challenge, gathering the signed forms by various means including an exemplary Super Tuesday election day effort held at voting precincts throughout Florida. This mission is now accomplished and the November 8 election day is eagerly awaited to learn the pleasure of the Florida electorate.

Amid the task of seeking signatures, it was learned that Governor Bob Martinez planned to call a special session of the Legislature to deal with the devastating malpractice crisis in the state. The problem was that no one knew when it would be called so that planning could get underway.

With less than adequate notice, auxilians arrived in the capital city the first week in February and left a few days later with feelings of having come, saw and conquered. Success was sweet for a change.

The regular session of the Legislature convened in April and was anticlimatic to the special session and to the many tense years when medicine was only thrown a few bones here and there but with the malpractice cancer still festering. The FMA capital office was quiet, not raging as in years gone by.

"Days at the Capital" took on a special meaning as an event to personally thank the large majority of legislators for their efforts during the special session. The reception at the Governor's Club was elegant and entertaining with a festive and peaceful atmosphere, though it was known that those adversaries who will attempt to destroy the new legislation were hard at work in that context.

Auxilians and FMA leadership met together at that time and had an open forum with each other. This productive and dynamic exchange will again be on the program for 1989.

Individual Auxiliary members across the state are taking this summer to work in campaigns of physicians, physician spouses and friends of medicine in hopes of continuing the success of organized medicine on behalf of the citizens of Florida. If you are not out there participating in this endeavor you should be. This is a lifeline not a sideline if medicine pays your freight.

Mrs. James H. (Nancy) Corwin II
Chairman, Legislation
Neptune Beach

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

SEPTEMBER

Clinical Update: Acid-Peptic Disease, Sept. 1, Delray Comm. Hosp., Delray Beach. Contact: Ruth Stewart (407) 495-3248.

19th Annual Pediatric Labor Day Symposium, Sept. 2-4, Pensacola. Contact: Garth Grove, M.D. (904) 474-7101.

Risk Management Seminar, Sept. 8, Broward Co. Medical Soc., Hollywood. Contact: Broward Co. Medical Society (305) 525-1595.

AIDS Lecture Series, Sept. 9, Miami and Ft. Lauderdale. Contact: Richard Burton (305) 547-6867.

2nd Annual Clinical Update on Health-Behavior & Disease, Sept. 10, Hyatt Regency, Tampa. Contact: Ravji Bhatty, M.D. (813) 237-3914.

Magnetic Resonance Imaging A Technologists New World, Sept. 15-17, Holiday Inn, Lake Buena Vista. Contact: Martin Silbiger, M.D. (813) 974-2538.

Pediatrics for the Practitioner — Update on Infectious Diseases, Sept. 16, Sheraton Tampa East, Tampa. Contact: Herbert H. Pemerance, M.D. (813) 974-2538.

Current Concepts in the Diagnosis & Treatment of Adult Heart Disease, Sept. 16-17, New World Landing, Pensacola. Contact: Phyllis Connerley (904) 478-4460.

Fall Physician Cardiology Symposium, Sept. 17, Watson Clinic, Lakeland, Richard Mackesy (813) 680-7636.

ACLS Instructor Course, Sept. 17-18, USF College of Medicine, Tampa. Contact: Daniel Cavallaro, M.D. (813) 251-6911.

Basic Cardiac Life Support for Physicians, Sept. 19, University Comm. Hosp., Tampa. Contact: Jim Connolly (813) 972-7270.

The 14th Annual Gulf Coast Internal Medicine Conf., Sept. 23-24, New World Landing, Pensacola. Contact: Dolly Partridge (904) 434-4818.

Risk Management Seminar, Sept. 24, Charolotte Co. Medical Society, Charlotte County. Contact: Charolotte Co. Medical Society (813) 625-6229.

Tutorial Courses of Instruction In Acute Cardiac Care, Sept. 26-Oct. 1, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Rehabilitation of the Post-MI Patient, Sept. 29, Hyatt Regency, Tampa. Contact: Maureen McShane, M.D. (813) 254-1020.

Endoscopic Sinus Surgery: Medical and Surgical Considerations, Sept. 29, Inc. Riv. Mem. Hosp., Vero Beach. Contact: Erol Atamer, M.D. (407) 567-2005.

OCTOBER

Basic Trauma Life Support Provider Course, Oct. 1-2, University South Florida, Tampa. Contact: James Hilman, M.D. (813) 251-6911.

Heart Disease, Emotions & Stress, Oct. 5, Tampa. Contact: Stephen Glasser, M.D. (813) 974-2880.

Risk Management Seminar, Oct. 8, Pasco County Medical Society, Pasco County. Contact: Pasco County Medical Society (813) 848-1644.

ACLS Provider Course, Oct. 15-16, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

Risk Management Seminar, Oct. 18, Orange County Medical Society, Orange County. Contact: Orange County Medical Society (305) 841-6267.

Changing Concepts in the Management of Hypertension, Oct. 18, Grand Bay Hotel, Coconut Grove. Contact: Murray Epstein, M.D. (305) 547-6716.

VI Annual Advanced Neuroradiology Seminar, Oct. 21-23, Hyatt Regency Hotel, Orlando. Contact: Agnes Bridges (813) 251-7778.

Risk Management Seminar, Oct. 22, Volusia County Medical Society, Volusia County. Contact Volusia County Medical Society (904) 255-3321.

Cardiac Pacing and Electrophysiology — 1988, Oct. 22-23, Innisbrook Resort, Tarpon Springs. Contact: Peter Alagona Jr., M.D. (813) 870-4155.

Risk Management Seminar, Oct. 29, Holiday Inn, Altamonte Springs. Contact: M.P. Demos, M.D. (800) 431-3878.

NOVEMBER

Traumatic Spinal Cord & Head Injury, Nov. 3-4, Holiday Inn, Pensacola Beach. Contact: Rose Marie Harvey (904) 474-5358.

Risk Management Seminar, Nov. 12, Airport Hilton, Tampa. Contact: M.P. Demos, M.D. (800) 431-3878.

AIDS Lecture Series, Nov. 17, Miami and Ft. Lauderdale. Contact: Richard Burton (305) 547-6867.

Directions in Pediatric Hematology/Oncology Care, Nov. 17-19, Harbour Island Hotel, Tampa. Contact: Cindi Butson (904) 375-6848.

ACLS Provider Course Provider Course, Nov. 26-27, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

DECEMBER

Risk Management Seminar, Dec. 3, Holiday Inn Calder, Miami. Contact: M.P. Demos, M.D. (800) 431-3878.

Tutorial Courses of Instruction In Acute Cardiac Care, Dec. 5-10, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Clinical Allergy & Immunology for the Practicing Physician, Dec. 8-10, Lake Buena Vista. Contact: Richard Lockey, M.D. (813) 972-7631.

First Annual Ocala Cardiovascular Day, Dec. 10, Ocala Hilton, Ocala. Contact: Rhonda Grubbs (904) 351-7206.

Basic Trauma Life Support, Dec. 10-11, Univ. South Florida, Tampa. Contact: James Hillman, M.D. (813) 251-6911.

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CENTRAL AND COASTAL FLORIDA/NATIONWIDE opportunities available now for BC/BE physicians. Complete confidentiality, send CV or telephone: Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, (813) 968-3878.

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IMMEDIATE NEED FOR A BC/BE Neurosurgeon to join successful, solo practitioner in Florida. Supported by 750 bed medical center, opportunity offers a ready-made practice in this beautiful, coastal community of 200K. Contact Jim Davis, Tyler & Co., 9040 Roswell Rd., Atlanta, Ga., 30350. Call (404) 641-6411.

TAMPA BAY AREA — Neurology, O/S, EM, IM, Occ. Med. Send CV to M.C.A., P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

PSYCHIATRISTS — FLORIDA: Immediate openings for Psychiatrists at Northeast Florida State Hospital located 30 minutes from Jacksonville, 50 minutes from Gainesville. Comprehensive benefit package including malpractice insurance. Salary negotiable. Board eligible or certified preferred. Hospital has affiliation with University of Florida, Department of Psychiatry. Clinical faculty appointment available for qualified applicants. Supervisory position available for qualified applicant. Contact: E. Zebooker, D.O., (904) 259-6211, ext. 111, NEFSH, Macclenny, FL 32063 EOE/AA

PHYSICIAN WANTED — Immediate opening full or part time — HMO Office Fort Lauderdale, Florida. Call Debbie (305) 981-4444, Associated Medical Centers of Broward.

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FAMILY PRACTICE: Marshfield Clinic is seeking BE/BC Family Practitioners to join its expanding department in Marshfield. The department is currently staffed by five Family Practitioners with plans to add three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available inhouse. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. Salary and fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715) 387-5376.

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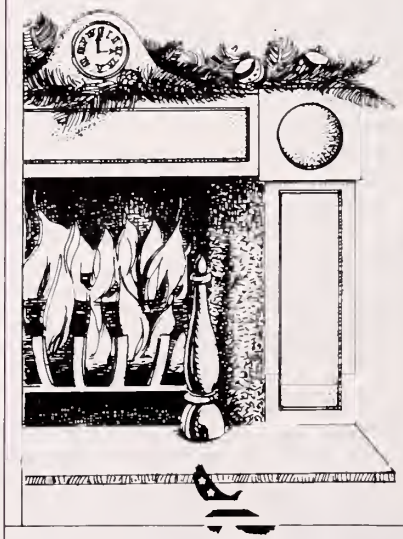

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Feature Editor — **Dale C. Havre, M.D.**

Medical Care System: Bigger But Not Better

What do a 19th century mortising machine and Medicare have in common? Plenty. I recently saw the machine at the Henry Ford Museum in Dearborn, Michigan, and the similarities to Medicare in both concept and structure were striking.

The mortising machine was designed to create a rectangular pocket in wood. Into that pocket fits a protruding tongue of wood fashioned from a second piece of wood. When the two pieces are mated and glued together, a very strong joint is produced. Before such machines existed, the job was done by skilled craftsmen with a hammer and chisel.

The apparatus I inspected in the Henry Ford Museum stood over six feet tall, possessed a dendriform collection of levers and knobs, and probably weighed over 500 pounds. Actually, it did have many of the characteristics of a successful NFL linebacker. It was truly an imposing structure, and it was all built to drive a little one-by-six inch chisel into a piece of wood. It took me 15 minutes to find the "working" end of the machine because the pitifully plain chisel was surrounded by such a maze of gears and wheels and other assorted cast-iron doodads.

What does this have to do with Medicare, you ask? Well, didn't Medicare do for medicine what the mortising machine did for the chisel? Medicare surrounded medicine with a bureaucratic maze of cast-iron rules and literally began to control its impact on society. Lost somewhere in that apparatus is the doctor who is desperately trying to do his job. (Please, let us not carry the analogy so far as to call the doctor a chiseler!) More and more, the instrument that evolved to do the work controlled the output and the chisel just went where it was directed.

But there are also signs of hope in the Henry Ford Museum. There is a massive, block-long locomotive on display that could pull 60 loaded coal cars up the steep slopes of West Virginia mountains. The boiler on that engine held enough water to supply a small city. Miles of tortuous pipes directed steam into and out of places I don't even want to think about. Engineering marvel that it was, though, the gigantic iron horse was replaced by a diesel locomotive that is one fourth its size and weight. Bigger is not necessarily better, then, and I think that is what the American public will soon discover about the delivery of medical care.

The final lesson I learned about "progress" in Dearborn came from an examination of the four-wheel lunar rover the astronauts used to explore the moon. Despite its sophisticated mission, the vehicle itself was very simple in design. In fact, it looked rather crude in comparison with some of the early automobiles on exhibit in the Ford Museum. But it obviously did the job and it did it without a plethora of bells and whistles. So, more complicated is not necessarily better, either.

The mission of medicine is to provide excellent medical care to as many people as possible at a reasonable cost. We have to be wary of any system that purports to accomplish that objective by surrounding the "working end" of the mechanism (the doctors) with a complicated suprastructure of oppressive rules and regulations. Like the lunar rover, physicians cannot be functional when they are weighted down with unnecessary accessories. And unlike the mortising machine, we must not let so many gears and levers control our impact on the work at hand.

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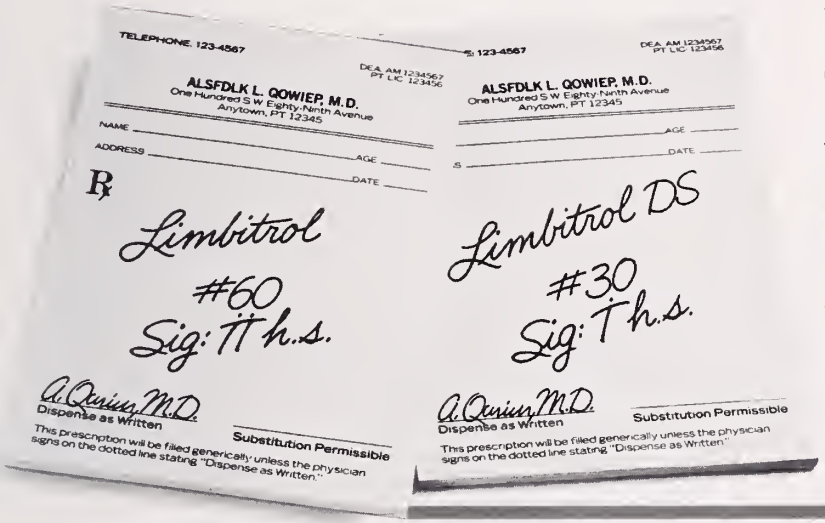

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Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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- First-week reduction in somatic symptoms[1]

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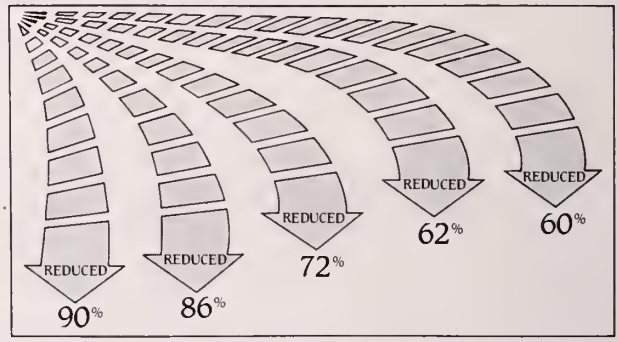
Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

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COVER

Autumnal splendor colors a stand of hardwoods heralding the arrival of the fall season. A work from photographer Eliot Porter's "Intimate Landscape" series, this month's cover is from the collection of Dr. M. Anwar Kamal, a Jacksonville plastic surgeon.

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THE ARMY RESERVE OFFERS NEW FINANCIAL INCENTIVES FOR RESIDENTS.

If you are a resident in Anesthesiology or Surgery*, the Army Reserve has a new and exciting opportunity for you. The new Specialized Training Assistance Program will provide you with financial incentives while you're training in one of these specialties.

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Putting Caring Into Medical Care

Time surely does fly when you're having fun! I cannot believe how quickly this past year has gone. It has brought many memorable occasions for me, but the most rewarding has been my contact with our members. I had the opportunity to visit most of our component medical societies and associations and I can truthfully say that I enjoyed all the visits.

The thing that is most encouraging is that the FMA has thousands of warm and caring physicians. Returning home, often late at night on a chartered airplane, I had time to reflect on my visits, and I often anguished that we fail to demonstrate to the public and the press that the overwhelming majority of our physicians are competent and compassionate people. In all my contacts with the press, not a single reporter ever asked a question about "good doctors;" instead they all wanted to know what we planned to do about the "bad doctors" or how much money doctors make.

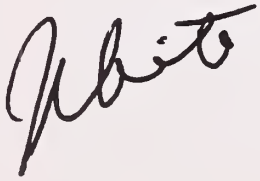
The theme that we chose this year was "Getting Back to Basics," and we wanted to stress putting caring back into medical care. Dr. Dale C. Havre wrote a splendid article in the February issue of the Journal on just this subject. As I read and reread his article, I think he somehow got inside my mind. Another excellent article by Madelyn Butler, a medical student and FMA member from the University of Florida, appears in this month's issue. Please read both these articles and you'll understand why I chose this year's theme, "Getting Back to Basics." Until we get out of the high-tech, money-oriented approach to medicine, we are never going to regain the respect of the public.

The most effective way to get our story to the public is through our mini-internship program. Most of the larger medical societies have started this program and they have generally been successful. With continued effort we can get our message out all across the state.

Another effective way is to get involved in your community so you will be seen as a "real person." Volunteer to be a team physician, serve on the Chamber of Commerce, United Way, etc. Continue to show the public the caring side of the medical community.

Let me say in closing how honored I am for your permitting me to serve as your President. We have a great organization and auxiliary with a superb staff and they all deserve your support.

Oh, yes, one more thing — YES on 10!



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Blank space indicates that no such activity has been reported.
Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975, 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. (see ADVERSE REACTIONS: Respiratory Depression).
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: As with any narcotic analgesic agent, VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.
Information for Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex, as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.
The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of material opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.
Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related.
The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total 24 hour dose should not exceed 8 tablets.

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EDITORIALS

The Message Is Loud and Clear

The nation's eyes will be focused on Florida and California this coming November as voters in the two states decide the fate of two landmark referendums. Floridians will vote on Constitutional Amendment 10 designed to cap noneconomic damages in civil liability suits to $100,000; Californians will do the same on Proposition 106 which would place strict caps on lawyers' contingency fees.

A common ingredient which impelled the birth of these two referendums has been the high, often unaffordable cost of liability insurance which has generated a crisis for physicians and which is now adversely affecting every segment of American society. The situation is particularly acute in Florida where physicians are held bondage by a system that threatens access and availability of medical care to citizens of the state.

The referendum in California was initiated on top of an already existing $250,000 cap on noneconomic damages in medical malpractice suits, passed by the state legislature in 1976. The cap has lowered and stabilized malpractice premiums and has laid to rest the spurious contention by lawyers that setting caps would not put a dent in the professional liability problem. Proposition 106, by setting caps this time on contingency fees, would stabilize the situation further. It would limit lawyers' fees to 25% of the first $50,000 in an award, to 15% of the next $50,000, and to 10% of any award over $100,000. That means that a $1 million award will net a lawyer $110,000, as opposed to the standard $330,000 that the system now allows.

Astronomical awards by juries and judges in civil liability suits along with the contingency fee system are the major forces that have fucled an explosion in litigation and a skyrocketing rise in liability premiums. A Rand Corporation study in 1985 found the average cost of a tort lawsuit to be over $33,000 and that close to 50% of the money goes to lawyers. A similar study by a special task force in Florida two years ago arrived at the same conclusion.

It would have been easy to stem the liability crisis that has enveloped Florida and other states the past several years by sensibly approaching the problems and seeking appropriate solutions. But lawyer-dominated state legislatures have been notoriously timid in taking action while aggressive trial lawyers have fought every attempt at reform of the system and continue to wield a stranglehold on a large segment of American society. We continue to hear the specious and trite arguments from trial lawyers that the contingency fee system is the poor man's ticket to the courts and that every individual is entitled to be compensated for every conceivable ill or affliction, no matter how trivial or nonexistent. What the lawyers don't mention is that the system is good for their pocketbooks, but bad for the rest of Americans. The majority of Americans, alas, have awakened to the reality of the situation and are now telling trial lawyers that enough is enough.

Polls indicate that there is overwhelming public support for both Constitutional Amendment 10 and Proposition 106; 80% of Californians would vote for Proposition 106 if the election were held today. The passage of both referendums would not abridge an individual's right to seek redress in court for a personal injury nor would it limit the ecomonic damages awarded in a civil liability suit. It would restore reason and order to a system that needs to be drastically overhauled and put a stop to the lottery mentality that generates the excessive number of lawsuits that we have today. It would also allow physicians, other professionals, and businesses to pursue their trades and occupations without the threat of a catastrophic lawsuit dangling before them every day.

Florida and California have always been considered as bellwether states, and the potential passage of the two referendums is certain to stimulate similar movements across the country. The clear message here is that Americans are tired of the endless parade of litigations and that we must draw a line somewhere to end this insanity. We will continue to need the services of lawyers for the forseeable future, but Americans are also bluntly telling them to back off and to release their stranglehold on the rest of us. That, at least, is more civil that what Shakespeare had suggested about lawyers several years ago.

R.G. Lacsamana, M.D.
Editor

Empty Lockers

Editor's Note: The following is the 1st place winner in the Best Editorial category of the 11th Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins.

It was 4:00 a.m. in a typical night in the life of an Obstetrician. My patient had been admitted to Labor and Delivery at noon the previous day. Her membranes had ruptured some twenty hours before admission and wishing to minimize her hospital stay, she had decided to remain at home until labor was well-underway. She waited but nothing happened. Reluctantly, she telephoned her husband who, in near-panic, rushed her to the hospital.

So here she was, a primigravida with twenty hours of ruptured membranes, no labor, and a green cervix. In hopes of avoiding a septic catastrophy, oxytocin induction of labor was begun. We *waited.* As expected, progress was slow. By 2:00 a.m. the cervix was only seven centimeters dilated. Fifteen minutes later the fetal monitor showed loss of fetal heart variability (a potential sign of fetal distress). In spite of changing the mother's position and giving oxygen, the fetal scalp electrode sent the same unwavering signal. A fetal scalp blood ph was obtained and read as 7.23. I *waited.* Twenty minutes later a repeat scalp ph was 7.20. The baby was unquestionably in trouble. The tempo accelerated as a stat cesarean section was orchestrated with the quick response of the pediatrician, anesthesiologist, and the O.R. team. Minutes and several lifetimes later, we were serenaded by the robust cry of a seven pound, eight ounce baby girl. It was 3:30 a.m.

I could feel that old familiar cloak of fatigue wrapping around me as it always does in these wee hours when the crisis has passed and the adrenalin pump returns to standby mode. From around the corner, and through the door the cool sheets of the bed in the call room beckoned to me. Fighting the magnetic pull, I pried open the chart for one last review of the day's events. Then I composed a detailed written documentation of all that had transpired over the past twenty-four hour. This, after all, would be my only legal defense should this baby not bloom into a prima ballerina, or a corporate executive someday.

Having put this burden to rest, I made my way to the locker room to change out of my sero-amniotic-soaked scrubs into something more pleasant (if that is possible). As I stood there in the stagnant silence, my sleepy eyes gazed over a sight that had somehow, until this moment, eluded me in its total profundity. There, scattered about the room, were symbols of a bygone era. Names flickered in the dim light like small candles at a seance. "Cooper, Curry, Messer. . .Crane, Griner. . .Moreton." There lockers stood mostly empty. A few had medical journals, novels, or old blood stained delivery shoes left in them. A tie hung inone; testimony of a harried dash to the delivery room or perhaps just as harried a dash home in an effort to arrive in time to join the family for dinner.

These men had practiced obstetrics long before I arrived in Tallahassee. Each had contributed something unique to the specialty in the community, and yet collectively they represented a vanishing breed of obstetricians. They were the last of a fading group who had been trained to perform operative forcep deliveries and vaginal breech births. They were equally comfortable performing cesarean-hysterectomies when necessary.

Over the years they had supported the introduction of prepared childbirth, and the tenets of LaMaze, Bradley, and LeBoyer. They had witnessed the birth of electronic fetal monitoring, ultrasound, and a staggering array of fetal surveying techniques. They had also witnessed rising c-section rates, skyrocketing liability insurance premiums, and the arrival of the "O"s.

Today they are conspicuously absent from our obstetrical staff. Their reasons for leaving are varied (at least on the surface). For some it was simply time to quit and get a well-deserved rest. For others a change of surroundings was necessary. But it is no secret that a common denomintor for all was the ever-increasing stress of soaring insurance costs and the constant threat of litigation. In a supposed "happy" specialty where perfection is expected there is no longer any allowance for "poor outcome." These unreasonable expectations coupled with the escalating overhead created by the insurance industry, and downwardly spiraling returns exacted by the HMOs, PPOs, etc. have resulted in an untenable situation for an ever increasing number in our specialty. Perhaps in the future

only the strong of purpose (or the weak of mind) will survive.

And so in these pre-dawn hours, it seems that I was summarily struck by the absence of my friends and colleagues who had so often chatted with me in these busy corridors. I realized that I would no longer smell Howard's cigar, or hear Michael's delightful accent. Neither could I look to Charlie for his wise and simple dvice, or to Ed for his calm and practice assurance. And who could ever match Calvin's dry wit and clinical excellence or Hutson's comic relief and surgical expertise? My mind reeled as I pondered these heavy thoughts. I couldn't help but wonder who would be next, and when my time would come.

I am certain that, as in many things to do with life (and death), the loss is greater felt by those who stay behind than by those who move on. So I am somewhat comforted by the realization that the previous occupants of these lockers have, at last, found some happier moments. Perhaps it came with starting anew in another town, or working without the axe of litigation constantly swinging overhead. Maybe now it is possible to engage in a serious family conversation, or attend a child's play, or go to sleep without the likelihood of being called for a stat delivery. Yes, there is certainly life after OB.

As for me, I plan to keep up the pace as long as my pocketbook, family, and spirits allow. The greatest challenge nowadays lies in being able to strike a sensible balance. Like all of us in this specialty, I realize the days are limited before my locker too will be empty!

John Taylor, M.D.

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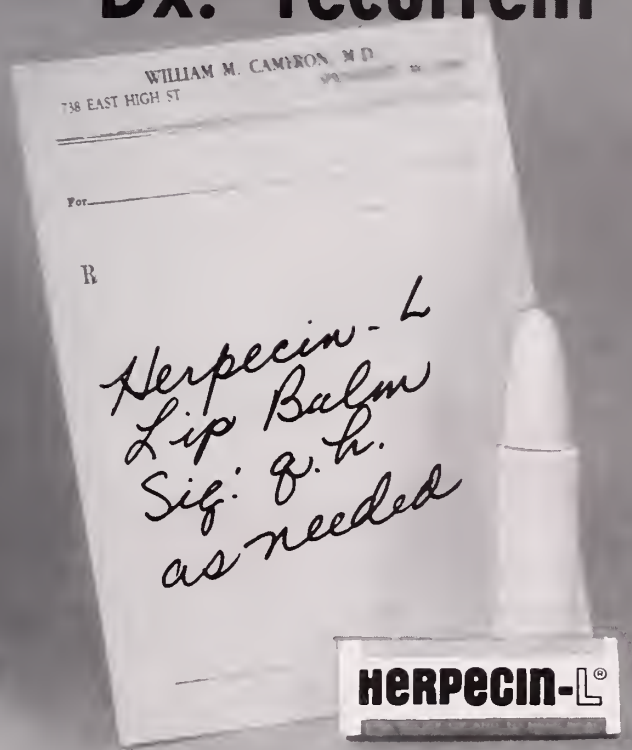
Dx: recurrent herpes labialis



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LETTERS & VIEWPOINTS

Photographs for *The Journal*

I am writing to inquire if you ever accept contributions (in my case, photographs) to be considered for the cover of the FMA Journal. If so, are you able to advise me if transparencies, color negatives or prints are desired.

H.R. Torrance, M.D.
Orlando

***Editor's Note: We are pleased to inform Dr. Torrance that we will be happy to consider photograph contributions from physicians for* The Journal.**

Who Will Be Emptying Bedpans?

I must reply to the letter of Dr. Samartino in the July 1988 issue ("What Went Wrong With Nursing?") as I find it inflammatory in nature, as well as being somewhat dangerous in content and highly prejudicial in style. As the husband of a B.S.N. for the past 12 years, I have witnessed from an active, not retired, point of view the trauma befalling the nursing profession. I cannot help but have a personal commitment to nursing welfare as a spouse, but much more than that is at stake as a practicing physician. I believe bilious attacks upon the nursing institutions, as from Dr. Samartino, will only serve to perpetuate the adversarial relationship between nurses and physicians which must end for true progress in the treatment of patients to occur.

When my wife was in her bachelor's program, I was a student in the medical college. Many of the nurses in the college were dissatisfied with the quality of medical instruction they were receiving, and often turned to the medical students for assistance. The nursing textbooks were laughably insufficient, especially in basic sciences. At one point the nurses wanted to learn more anatomy, and as the medical students were in the anatomy lab anyway, there was ample opportunity to become more knowledgeable. The nurses were rewarded for their initiative by being told by instructors in both colleges that "nurses should not know that much."

Three years later my wife took up her specialty of neonatal intensive care nursing. She was then called upon to perform intubations, do arterial and venous punctures, and evaluate EKG and x-ray results in the absence of physician assistance. I am aware at this time of no change in this system at my wife's present situation, and also of no change in the training of specialty care nurses at present which would better prepare them for such situations.

One hundred years ago there was little a medical physician could do to intervene in the natural course of disease. It is impressive to find how much nursing has contributed to the scientific base of medical practice. To use Dr. Samartino's example — in Vienna in 1847 it became apparent to an assistant physician at the obstetrical clinic there was a marked disparity in postpartum death between the physician clinic and the adjoining midwives' clinic. Such was the appalling death rate at the physician clinic that women begged to wait in their labor or simply had their babies on the doorstep if they could not gain admittance to the midwives' clinic. Dr. Semmelweis, after much investigation, realized the cleanliness techniques pursued rigorously by the midwives were the main contributor to this disparity in death rates, but even now, 140 years later, physicians remain the worst practitioners of the art of handwashing, according to several well-published studies. It would seem that the educational system more in need of review would be the physicians'.

How nurses must be educated is dictated by the role they must play in modern medicine. As Dr. Samartino's letter amply illustrates, nobody has yet defined that role. As the application of interventional technology accelerates, nursing roles will be changing so fast that the establishment of a comprehensive general nursing curriculum may soon be impossible. How many drugs are nurses now responsible for administering under direct physician supervision (that is, the doctor is at the bedside)? Very few candidates even come to mind. How many contingency orders are written in every hospital today which presuppose the ability of the nurse to make a diagnosis as a condition of administration? The list is growing. If physicians are going to expect proper patient care under our present capabilities in medicine, then the physicians are going to have to realize how much medical training is required simply to understand how to carry out treatments considered standard in our hospital

system. It is up to us as physicians to ask (not demand) the nursing education system to let us work with them to produce nurses who will not be overwhelmed by nursing practice due to inadequate preparation. It is not a question of "if he/she wants to practice medicine, he/she should go to medical school," but a simple demand placed upon nurses by the real hospital world which their educational system is now ill-equipped to prepare them. Nurses must know more medicine, not less, and their education will look more like medical school curricula, simply because that is the direction the real world of nursing is taking.

At the same time, we must all understand how the hospital environment has changed in the past 20 years. Even as a resident ten years ago I experienced some of the novelty and experimentation that was still extant with regard to that innovation-the CCU. Twenty years ago my wife would not have even been able to find a place outside Boston to be a NICU nurse. Just as medicine has evolved to meet with exploding technologic advances, so must nursing now separate the duties of medical management from custodial functions. If the result of increasing complexity is extinction, then we physicians will be gone long before the nurses.

We all have had the experience of talking to a nurse in the middle of our day or night who, when given an order, appears to misunderstand or misinterpret that order. We have also seen the blind acceptance of a physician's order to the detriment of the patient. These incidents will increase geometrically as we ask fewer well-trained nurses to do more work with more patients. The nursing shortage is in part due to the increasing withdrawal of good people from a profession which gives them no credit, no recognition, and no respect (apologies to Mr. Dangerfield).

The bottom-line mentality of our hospital system is no help to nursing either. The hospital administrators appear to feel as Dr. Samartino, that "a nurse is a nurse is a nurse." ICU personnel are transferred to the floors on a regular basis to fill in where budgetary restraint does not permit full staffing. Even worse is the delegation of critical roles to these three-year "wonder nurses" of Dr. Samartino who would never have the basic science background to understand the reason for a specific order, or the meaning of subtle signs which might require immediate intervention.

It is the mentality of those, such as Dr. Samartino, who advocates returning nursing to the bedpan bridgade of the "good old days," which is sabotaging the efforts of organized nursing to achieve the goals society and physicians are setting. It is time we stopped this pointless defense of Doctor over Nurse or else it will be the physicians who will be emptying bedpans.

Lawrence A. Gaulkin, M.D.
Tampa

Editor's Note: The diametrically opposing viewpoints of Dr. Samartino and Dr. Gaulkin illustrate the dilemma in the nursing profession today; there is no clear consensus on what to do to end the nursing shortage. The AMA made a bold move in its last annual meeting by proposing a new cadre of nursing assistants: the RCTs (registered care technologists). But most nursing groups vigorously oppose the concept and have made known their dissatisfaction to the AMA in many ways. Most physicians agree on one thing: we need adequate numbers of nurses, whether they be RNs, BSNs, LPNs, or even RCTs. We cannot continue to fiddle or disagree while the nursing shortage is boiling over.

Why Does Back Surgery Have a Bad Name?

Since a good part of my neurosurgical practice involves surgery of the spine, I am frequently confronted with the perception that many persons who have had back surgery have not fared well. And, indeed, this is true. How then can I in good faith recommend surgery?

In order for spine surgery to be successful, a few principles must be strictly adhered to. It goes without saying that the surgery must be done skillfully and with exacting technique. Creating additional neurological injury is not acceptable and should occur only rarely. However, as important as technique is, the fundamental basis for successful back surgery lies in patient selection. Every patient who is chosen for surgery must fulfill certain criteria. One requirement is that an anatomical abnormality of the spine is demonstrated which can be surgically corrected or at least improved upon. Another one is that the patient must have symptoms which are caused by the anatomical abnormality. The patient should have two or more of the following symptoms or signs: back pain, radicular leg pain, a positive straight-leg raising test, muscle weakness, diminished or loss of deep tendon reflexes, numbness or paresthesia. If these guidelines are faithfully followed, the results are usually good.

These principles are easily understood and seem to make intuitive sense. How are they then violated? Usually, in one of the following ways:

(1) No significant radiographic abnormality present. Sometimes, examinations such as a myelogram will be outright normal and yet the person is subjected to surgery. Or there may be an equivocal abnormality, such as a midline bulge on the magnetic resonance (MR) scan. MR scan is a new technique and there is still a good deal to be learned as to what is normal or abnormal. But MR scans can be overread with such regularity and

consistency that it is alarming. This is not accidental. Often a person with a liability suit stemming from an accident will have a MR scan performed. Sometimes the patient is referred by the plaintiff's attorney himself. The monetary worth of such a case is increased measurably by a positive scan. And to make matters worse, a surgeon may recommend an operation based solely on a report of a positive scan.

(2) Symptoms are not caused by nerve root compression. The patient may have back pain only. Symptoms which would indicate nerve root compression are absent. In these patients, even if an abnormality is present on spine x-ray or scan, surgery is still not indicated.

(3) Secondary gain factors. This is one of the more important reasons for unsuccessful back surgery. A common example is the person with a liability case arising from an accident. In order for the case to be worth anything, there must be bodily injury. If there is no real (or very little) injury, the patient is obliged to prove that he is injured. A common method is to focus on the spine and complain of back or neck pain. Eventually, surgery is recommended because "nothing else is working." The same is true for workers' compensation cases. It has long been known that patients having disc surgery, who are workers' compensation cases, fare worse than other patients, all other things being equal.

(4) Surgery done out of desperation. These cases always fail. I frequently will be told, "Doctor, you have to do something. I can't go on like this." This is a typical statement from a chronic pain patient who is likely depressed and may be addicted to narcotics. Surgery is justified, presumably, because "nothing else has worked." Surgery can be done but, if it is, it will merely be added to that long list of things which hasn't worked.

Back surgery's bad reputation did not evolve without reason. It will continue to exist for as long as patient selection or the operative procedure is performed badly. When we physicians see the principles of good medicine violated, we cannot look the other way because "it's none of my business." Peer review requiring discipline of our colleagues is the most difficult task we are asked to do — more difficult than the practice of medicine itself. It is something only we can do. And it is something we must do. No less than the very lives and health of our patients are at stake.

Amos Stoll, M.D.
Fort Lauderdale

Opposed to Out-of-State Ads

Over the years, I have enjoyed the scope and content of our Florida Medical Journal. The balance in terms of history, current information, current articles, and even Letters to the Editor has been well done.

As a specialist in rehabilitation, it is with some embarrassment that the current July 1988 issue subscribes to the advertisement of an out-of-state rehabilitation center, as demonstrated on the page before page 437 of the July issue.

Although rehabilitation medicine and rehabilitation centers are low-key in our state, recent growth in certified rehabilitation facilities and an increase in Board-certified PM&R specialists attest that rehabilitation is available without sending Florida citizens out-of-state.

I realize this is a business decision for our Journal; however, this might not be as clear to other physicians.

I would ask your Advertising Editor for a policy comment on The Journal's selection of advertising that does not encourage full utilization of the facilities already in place in our state.

Even with the realization that this is a matter involving less than 50 Florida physicians, it is of individual patient importance.

Would it be helpful for The Journal to utilize a future issue to better describe Florida's rehabilitation facilities and the advantages of rehabilitation for our patients in general?

Frank W. Moreau, M.D.
Sarasota

Editor's Note: **The Journal** ***does not have a policy banning out-of-state ads in its pages. Publishing such ads, however, does not carry the endorsement of*** **The Journal,** ***and that is true for ads coming from within the state as well.*** **The Journal** ***recognizes the advances in physical medicine and rehabilitation and would be tickled pink to receive contributions from Dr. Moreau and his colleagues.***

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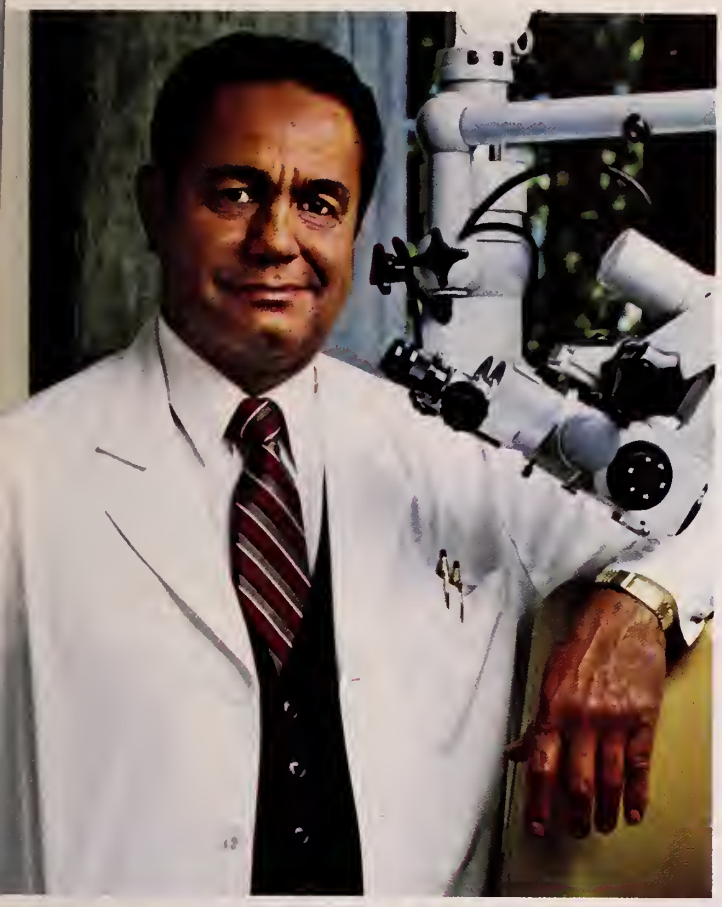

DALE L. TIPTON, M.D.

Associate Clinical Professor, Department of Otolaryngology, Head and Neck Surgery, University of California School of Medicine, San Francisco, California.
Chairman, Division of Otolaryngology, Franklin Hospital, San Francisco, California.
Lieutenant Colonel, U.S. Army Reserve.

EDUCATION University of California at Berkeley, A.B. Physiology; University of California School of Medicine, San Francisco, M.D. and Master of Science, Pharmacology.

RESIDENCY University of California School of Medicine, San Francisco: General Surgery – 2 years; Otolaryngology – 3 years.

FELLOWSHIPS National Institute of Health Fellow; Cancer Research Institute, University of California, San Francisco.

OUTSTANDING ACHIEVEMENTS Freshman Medical Student Research Award; Class President – 2nd year medical school; Student Body President – senior year medical school; Special Award by National Institute of Health to attend and present paper at International Congress of Otolaryngology in Tokyo, Japan; Chairman, Department of Otolaryngology, San Francisco General Hospital 1970-76; Chief of Medical Staff, Franklin Hospital 1982-84.

Dr. Tipton and residents examining post-operative patient in recovery room.

"I joined the Army Reserve shortly after completing my responsibilities as Chief of Staff of Franklin Hospital in San Francisco. I was intrigued with the idea of trying something different, such as Army Medicine.

"I find that the challenges and rewards of serving as an Army Reserve physician complement my civilian practice. For a number of years, I've been teaching as a member of the Clinical Faculty at the University of California School of Medicine, and I thoroughly enjoy the many teaching opportunities available to me in the Reserve. It is a rewarding experience to be involved in the training of Army medical students, interns, and residents. I also enjoy interacting and exchanging information with full-time Army physicians and seeing a wide variety of interesting clinical cases.

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Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGDT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGDT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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Surgical Management of Bilateral Carotid Body Tumors with Carotid Artery Stenosis

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ABSTRACT: ***A report is presented of the surgical management of a patient with bilateral carotid body tumors and significant carotid stenosis. Diagnostic criteria and surgical technique are discussed for simultaneous removal of the tumor and performance of carotid endarterectomy.***

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The patient is a 62-year-old hypertensive, white female who presented with an episode of blurred vision, otherwise asymptomatic. Pertinent physical findings were a right carotid bruit and prominence to palpation of the left carotid artery. Angiograms revealed bilateral, highly vascular carotid body tumors measuring 2.5 cm in diameter (Fig. 1). There was also an 80% stenosis of the termination of the right common carotid artery. The patient underwent resection of the right tumor and a right carotid endarterectomy.

A 2.5 cm highly vascular tumor was attached to the carotid artery bifurcation. There were multiple, delicate adhesions between the mass and the adventitia of the common, internal, and external carotid arteries. Umbilical tapes were placed around these arteries beyond the mass. Care was taken to avoid injury to the hypoglossal and vagus nerves. The mass was carefully dissected away from the surrounding tissues with several small branches of the external carotid artery feeding the tumor being ligated and transected. The tumor was separated from the carotid bifurcation with Metzenbaum scissors and removed in toto after severing attachments to the adventitial layer of the external, internal, and common carotid arteries.

The dissection did not hinder subsequent performance of the carotid endarterectomy. Heparin, 5000 units, was administered intravenously and, with no vascular clamps being placed, a vertical incision was made in the common carotid artery at the bifurcation, then carried down to but not through the plaque with a Freer elevator being utilized to develop the plane between the plaque and the media of the artery. The incision was extended 1.5 cm on the common carotid artery and approximately 1 cm on the internal carotid artery to the upper limit of the plaque. A 6-0 prolene suture was placed at the caudal corner of the incision and vascular clamps on the internal, external, and

Fig. 1.—Angiogram showing right carotid bifurcation with stenosis of the termination of the common carotid artery and with highly vascular carotid body tumor.

common carotid arteries. The plaque was transected at its proximal aspect, then dissected from the media layer of the carotid bifurcation and from the proximal external and internal carotid arteries. The internal carotid incision had to be extended an additional 0.5 cm to reach a satisfactory level for adequate feathering of the plaque. The incision was closed with a 6-0 prolene suture. Carotid occlusion time was 11 minutes, 15 seconds. Postoperative course was uneventful and the patient was discharged on the third postoperative day.

Subsequent surgery for the opposite side was delayed by the patient for personal reasons for four and a half months. At that time, she was readmitted and a large vascular tumor was found at the carotid bifurcation wedged between and encompassing both the external and internal carotid arteries. The tumor was adherent posteriorly to both the carotid sheath and vagus nerve and more densely adherent to the adventitia of the arteries than the first tumor. Using tedious dissection, control of the external and internal carotid arteries above the tumor was obtained. The tumor extended into two branches of the external carotid artery and into the facial vein. All had to be sacrificed. It was separated from the adventitia of the common, internal, and external carotid arteries constantly oozing blood. Since the tumor densely adhered to the external carotid artery, bleeding from the artery required brief clamping and repair with a single, figure of eight, 6-0 prolene suture. In addition, it was necessary to shave the tumor off the vagus nerve before it could be completely removed.

The postoperative course was unremarkable, except for hoarseness, which has almost completely resolved after four and a half months.

Discussion ● Carotid body tumors, sometimes called chemodectomas, are rare neoplasms located in the region of the carotid artery bifurcation. They originate from neural crest paraganglion cells, are considered paragangliomas, and are associated at times with other paragangliomas including pheochromocytoma.[1] These tumors are usually unilateral but may present bilaterally in 5-10% of cases. At times, multiple cases are found in the same family and these instances are compatible with autosomal dominant genetic transmission. The incidence of bilateralness is approximately 30% in familial cases. These tumors are usually benign with less than 10% developing metastasis.[2] Growth rate is very slow and many patients present with a neck mass which has been evident for years. The mass, located at the carotid bifurcation, is generally nontender and can be moved horizontally but not vertically.[3] Cranial nerve involvement is not infrequent, particularly the vagus nerve, which was involved in the patient presented. Potentially involved are cranial nerves 7, 9, 10, 11, and 12 as well as sympathetic nerves and the recurrent laryngeal nerve.[4]

Needle biopsy is not recommended because of the extreme vascularity of these tumors.[5] Diagnosis is best obtained by carotid angiogram. In most instances, this reveals a very vascular tumor situated at the carotid bifurcation causing splaying of the internal and extrenal carotid arteries.[6]

Due to significant vascularity, some surgeons recommend use of the cell saver to minimize the need for transfusions.[7] Preoperative embolization of arterial branches of the external carotid artery feeding the tumor has been reported.[8]

The tumors adhere to the carotid artery. Shamblin divides them into three groups. Group I adheres to the carotid bifurcation but can be removed without injury to the artery; Group II are more adherent to the adventitia of the artery and partially surround the artery but can be removed with subadventitial dissection; Group III are more advanced and more adherent to the artery making separation impossible.[9] Removal may require sacrificing the involved segment of artery and replacing it with a graft, preferrably of saphenous vein.

In our patient, the right tumor was in Group I and easily separated from the artery without adventitial injury which would have complicated carotid endarterectomy. The left tumor was in Group II and required subadventitial dissection and entry into the lumen of the vessel for complete removal.

The tumor on the right side in this patient was

excised first because of a concomitant 80% carotid stenosis. If the left side had been done first and removal had necessitated resection of the left carotid artery, the risk of stroke would have been increased. The carotid endarterectomy, utilizing the technique demonstrated at the 1983 American College of Surgeons meeting, was performed without a shunt and with the majority of the separation of the plaque from the vessel wall being accomplished prior to placement of any clamps on the carotid arteries.[10] This shortened the carotid occlusion time and allowed the procedure to be performed in a less hurried fashion.

Summary ● This patient had bilateral carotid body tumors and significiant carotid stenosis. The right tumor was removed by severing attachments to the carotid artery adventitia after ligating its blood supply. This did not interfere with the carotid endarterectomy which was performed without use of a shunt with the majority of the separation of the plaque from the adventitial layer being accomplished prior to placement of clamps on the vessels. The left tumor was more adherent to the carotid bifurcation and required subadventitial dissection and even entry into the lumen of the external carotid artery before it could be excised.

References

1. Farr, H.W.: Carotid Body Tumors: a 40-Year Study, CA 30:260-265, 1980.
2. Grufferman, S., Gillman, M.W.; Pasternak, L.R.; Peterson, C.L.: et al: Familial Carotid Body Tumors: Case Report and Epidemiologic Review, Cancer 46:2116-2122, 1980.
3. Davidge-Pitts, K.J. and Pantanowitz, D.: Carotid Body Tumors, Surg. Annu. 16:203-227, 1984.
4. Borges, L.F.; Heros, R.C., and DeBrun, G.: Carotid Body Tumors Managed with Preoperative Embolization: Report of Two Cases, J. Neurosurg. 59:867-870, 1983.
5. Meyer, F.B.; Sundt, T.M., and Pearson, B.W.: Carotid Body Tumors: Subject Review and Suggested Surgical Approach, J. Neurosurg. 64:377-385, 1986.
6. Lees, C.D.; Levine, H.L.; Beven, E.G., and Tucker, H.M.: Tumors of Carotid Body: Experience with 41 Operative Cases, Am. J. Surg. 142:362-365, 1981.
7. Padherg, F.T., Cady, B., and Persson, A.V.: Carotid Body Tumor: Lahey Clinic Experience, Am. J. Surg. 145:526-528, 1983.
8. Lasjaunias, P.; Menu, Y.; Bonnel, D, et al: Nonchromaffin Paragangliomas of Head and Neck: Diagnostic and Therapeutic Angiography in 19 Cases Explored from 1977 to 1980, J. Neuroradiol 8:281-299, 1981.
9. Shamblin, W.R.; ReMine, W.H.; Sheps, SG, and Harrison, E.G. Jr.: Carotid Body Tumor (Chemodectoma): Clinicopathologic Analysis of Ninety Cases, Am. J. Surg. 122:732-739, 1971.
10. Arrants, J.E.: Modified Non-shunt Endarterectomy. Cardiovascular surgery session of the motion pictures exhibition. 1983 Clinical Congress of American College of Surgeons.

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Brainstem Cryptic Arteriovenous Malformations

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ABSTRACT: ***Vascular malformations of the brainstem and thalamus most often discovered incidentally rarely produce symptoms. We have studied six cases with computerized tomography (CT), angiography, and magnetic resonance (MR) imaging. Chronic hemorrhage was a prominent feature in five of the six cases and was particularly easy to identify with MR imaging. This and several other features, including stability of most of these admittedly rare lesions over long periods of time and characteristic pontine and brainstem locations, may be pathognomonic for these lesions, but a high index of suspicion must still be maintained.***

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Cavernous or telangiectatic arteriovenous malformations (AVMs) of the brainstem are rare with less than 50 cases reported in the world literature over the past ten years. Before advent of computerized tomography (CT), diagnosis was extremely difficult since most AVMs in this location are beyond the resolving power of cut film cerebral angiography and have no mass effect to be seen on pneumoencephalography.[1] Magnetic resonance imaging (MRI) is useful in identifying these lesions by its ability to better visualize vascular structures of small size and delineate the exact extent of surrounding brain reactive gliosis or ischemia, both of which might be represented by the same increased T2 on MRI. Recent observations allow identification of characteristic MR findings in chronic hematomas and make the diagnosis of a brainstem AVM which has bled much more certain.[2,3] The ultimate diagnosis depends upon strong clinical suspicion since CT and MRI images could conceivably be confused with neoplasia. Stability of the lesion over time on serial CT or MRI scans is essential in making the diagnosis since biopsy, even with CT or MRI stereotaxic guidance, carries considerable risk. Brainstem AVM does not appear to be a terminal disease as evidenced by survival of the six patients in this series, the largest ever reported. Included is a six-month-old girl, the youngest patient reported with brainstem AVM.

Material and methods ● Six patients, four females and two males, ages six months to 60 years, were referred to University Diagnostic Institute, Tampa General Hospital, or James A. Haley VA Hospital, Tampa, for imaging which eventually led to diagnosis of brainstem vascular malformations. All patients underwent CT scans on third and fourth generation scanners with and without intravenous contrast enhancement, and five had conventional cerebral angiographic studies

Fig. 1a

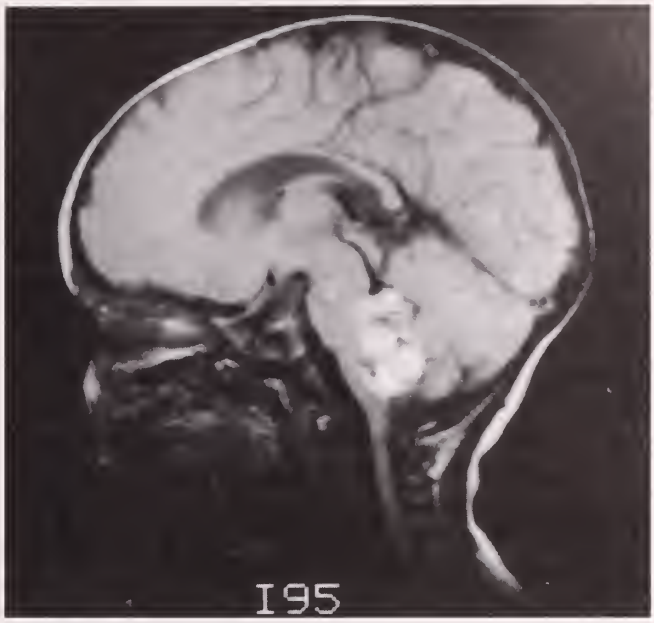

Fig. 1c

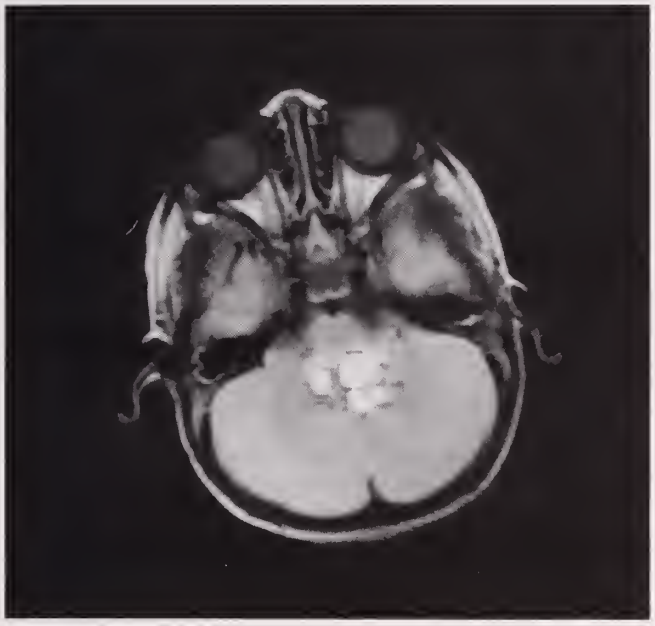

Fig. 1b

Fig. 1d

Fig. 1.—Axial CT examination (1a) without IV contrast shows mass effect and curvilinear calcifications in the pons. Axial T1-weighted image (1b), sagittal T1 (1c), and sagittal (1d) T2-weighted images obtained on a 1.5 Tesla GE Signa unit demonstrating multiloculated mass in dorsal pons and medulla with short T1 and long T2 characteristics; these ultimately were shown at surgery to be loculated chronic hematomata. Dark curvilinear bands surrounding the cavities are linear calcifications (1a) or hemosiderin.

which were read as negative. All six were evaluated with MR imaging on machines ranging from a Siemans 1.0T magnet operating at 0.35T, GE Signa system operating at 1.5T, or Diasonics and Technicare systems operating at 0.35 T. Diagnostic accuracy on review of scans was independent of field strength used for MR imaging.

Case studies

Case 1 ● This six-month-old white female was well until one month prior to admission when difficulty was noted with swallowing and sucking. A CT scan of the brain (Fig. 1a) with and without contrast demonstrated some mass effect in the dorsal pons and

midbrain, with curvilinear calcifications. A brainstem glioma was suspected and an MR scan (Fig. 1b) demonstrated multilocular areas of increased signal on both T1 and T2 weighted images in the dorsal pons and midbrain, believed diagnostic of old hemorrhage. Curvilinear areas of signal void corresponded in some locales to calcifications but most were thought to represent hemosiderin deposits. A cerebral angiogram was negative. The patient was stable and was transported to Children's Hospital in Pittsburgh where a dorsal surgical approach to the pons revealed old hemorrhage and a cryptic arteriovenous malformation. She recovered nicely after drainage of the hematoma.

Case 2 ● This 40-year-old white female experienced sudden onset of mild dysarthria, headache, left hemiparesis, and internuclear opthalmoplegia. History revealed no prior symptoms. A CT scan of the brain at another institution, with and without IV contrast, demonstrated hematoma in the dorsolateral portion of the midbrain on the right. An MR scan at University Diagnostic Institute several weeks after the initial episode (Fig. 2a) revealed an area of bright signal on T1 and T2 weighted images consistent with chronic hematoma. Areas of signal void around the lesion were believed to represent deposits of hemosiderin as a result of maturation of the hematoma. A hemorrhage into a brainstem AVM was diagnosed. She was transferred to a San Francisco hospital where a cerebral angiogram was read as normal. Attending physicians concurred with the diagnosis of midbrain telangiectatic or capillary AVM and she was treated with external proton beam irradiation. No rebleeding has occurred since the initial episode three years ago. Her deficits have improved slightly.

Fig. 2a

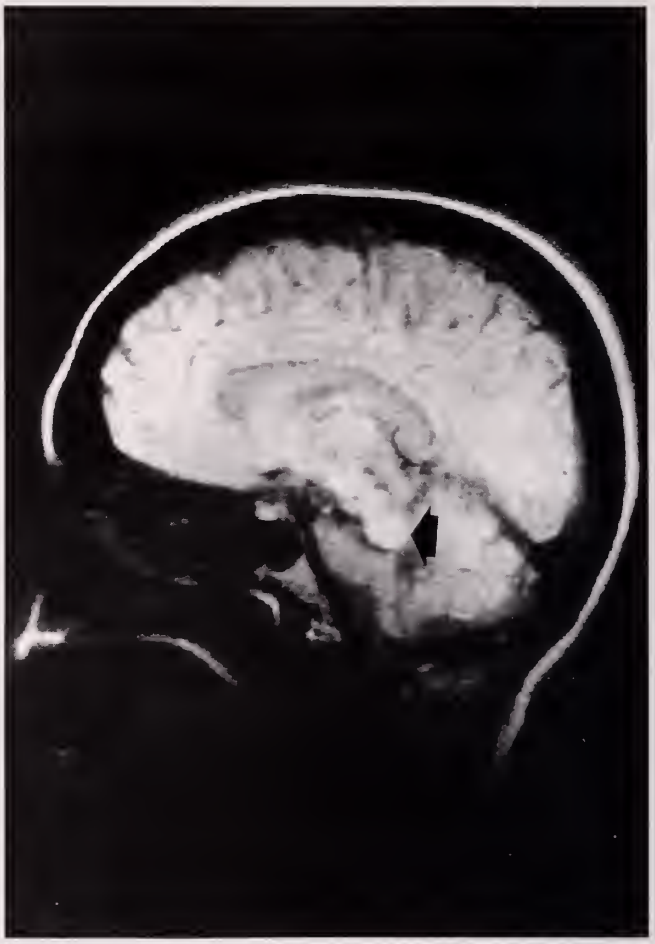

Fig. 2b

Fig. 2.—AP and lateral views of MR with T1 weighted proton density scan (parameters: TR=1.7, TE=1.5, Siemans 1.0 magnatom at 0.35 Telsa) show areas of signal void (small arrows) which probably represent hemosiderin around the larger bright signal area in the tectum (large arrows), this mixed prolonged T2 effect on a proton density scan, and was thought to be chronic hematoma in a brainstem AVM.

Case 3 ● A neurological deficit consisting primarily of progressive dysarthria and internuclear opthalmoplegia developed in a 35-year-old white male over a two or three year period. Four years after onset of symptoms, he had an angiogram at James A. Haley VA Hospital that revealed no abnormalities and a CT scan which demonstrated a small calcified area in the dorsomedial midbrain (Fig. 3a, b) subsequently enhanced after contrast administration. Follow-up CT

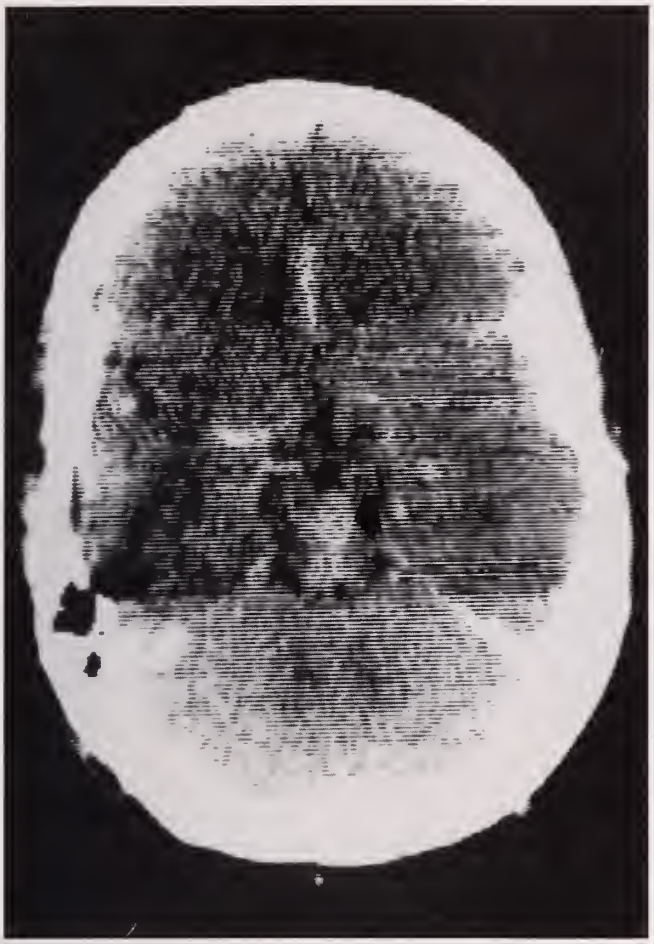

Fig. 3a

Fig. 3a.—CT scan of the brain with contrast demonstrates enhancing lesion without mass effect in the midbrain and tectum (arrow).

Fig. 3b

Fig. 3b.—AP view of left vertebral injection demonstrating absence of capillary filling of any arteriovenous malformation.

scans over a 16-year period showed no internal change. To our knowledge the patient never had an MR scan. The lesion was believed to be consistent with capillary telangiectasia or cavernous angioma, for which he received external radiation to the midbrain. His symptoms persist but have not changed significantly in the 12-year follow-up period. No further therapy or workup is contemplated.

Case 4 ● A 24-year-old white female experienced sudden mild headache and mild L sixth cranial nerve palsy. No CT was performed and after one year corrective surgery was advised to compensate for the paresis. Shortly thereafter headache occurred suddenly and she was hospitalized at another institution. CT revealed hemorrhage in the mid pons and MR scan (Fig. 4a, b, c) showed bright signal changes consistent with hematoma. She recovered and was followed by MR over several months as the midbrain lesion changed and signal-void areas appeared consistent with hemosiderin deposits. This patient functions well with her presumed brainstem telangiectatic AVM and prefers not to undergo external beam proton radiation or surgery.

Case 5 ● This 43-year-old white male has been followed at another institution for internuclear opthalmoplegia which occurred suddenly four years ago. Initial MR studies revealed an area of increased signal on T1 and T2 in the pons. A neoplasm was considered and attempts made to rule it out. The patient had a complete cerebral angiogram that was negative and received 5000 rads of external beam irradiation to the pons and midbrain for suspected malignancy. He did well for four years with no changes in symptoms. Follow-up MR scans (Fig. 5a, b) demonstrated evolution of the midbrain mass into a small lesion with bright signal on T1 and T2 and tiny areas of signal void within it, believed to be consistent with chronic hematoma in a brainstem telangiectasia and hemosiderin deposition.

Case 6 ● This 60-year-old white female had sudden onset of right hemiparesis six years ago, along with left conjugate gaze palsy. Some recovery occurred but symptoms recurred three years later. CT demonstrated a mildly calcific lesion in the midbrain which enhanced in the left cerebral peduncle. MR (Fig. 6a, b, c, d) demonstrated a very well defined area of bright signal on both T1 and T2 weighted sequences surrounded by a ring of signal void. Cerebral angiogram was negative and a diagnosis of brainstem telangiectatic AVM was made. Currently no further therapy is

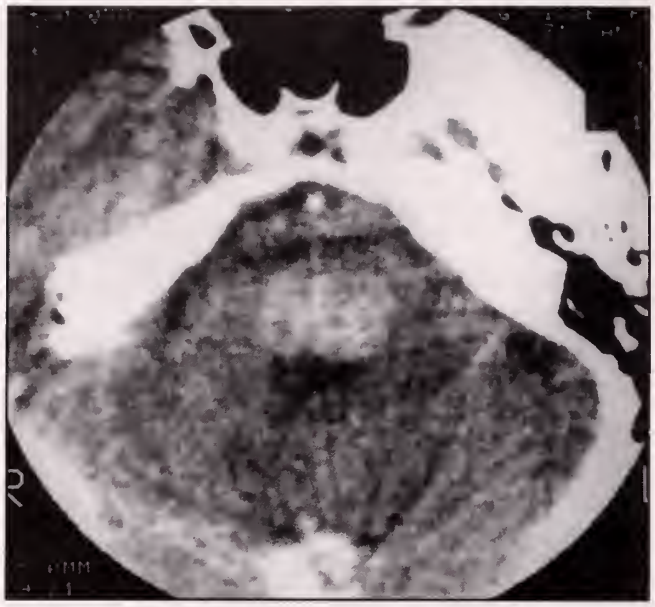

Fig. 4a

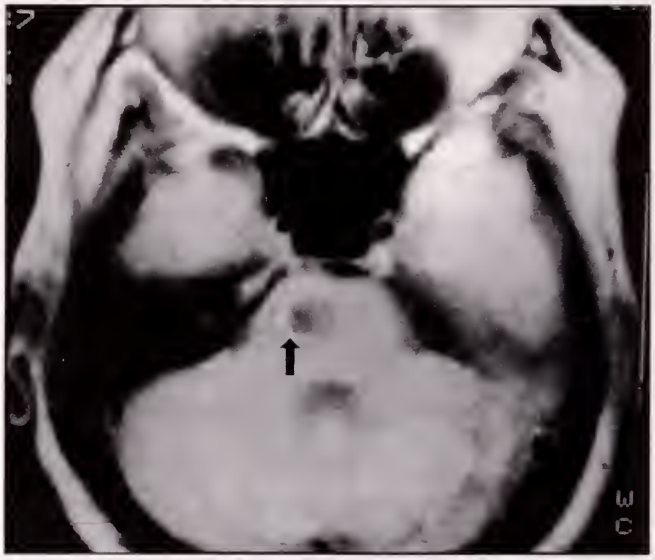

Fig. 4b

Fig. 4c

Fig. 4a.—I.V. enhanced CT scan of brain demonstrates enhancing lower pontine segment of AVM. This was performed approximately nine months after onset of symptoms and some calcification was also present to the right of pons on unenhanced scan.

Fig. 4b, c.—Axial T1 (b) and T2 (c) weighted images generated on a Siemens 0.35 T magnet system show chronic hematoma as presented by bright silver on right on pons of T1 and T2 weighting (arrow). A large signal void representing hemosiderin deposits and/or calcification has appeared and dominates the mid-central portion of the lesion.

planned and the patient is doing well with no change in symptoms for three years.

Discussion ● There are four currently recognized pathological types of vascular malformations found in the brain: capillary telangiectasias, cavernous hemangiomas, arteriovenous malformations, and venous angiomas. Large, hemispheric AVMs are readily diagnosed on all conventional imaging methods as are venous angiomas.[4] Capillary telangiectasias and cavernous hemangiomas are often more difficult to diagnose because of pathological anatomy but have common features which make them amenable to diagnosis on CT and MR.[2,3]

Capillary telangiectasias consist of dilated capillary blood vessels separated by normal neural tissue and are often solitary but have been associated with coexisting single or multiple cavernous angiomas. In the central nervous system capillary telangiectatic AVMs are most often located in or near the midline of the pons. McCormick et al[5] reported 75% of their 36 cases were pontine in origin, but other common sites included the midbrain, cerebral cortex, and subcortical white matter. Capillary telangiectasias are believed to be mostly clinically silent and rarely hemorrhage spontaneously.[1,5] In contrast, cavernous hemangiomas consist of aggregations of blood vessels of various sizes which can be distinguished from capillary telangiectasias histologically by the appearance of densely packed vessels with small amounts of gliotic parenchyma but no neural tissue interspersed between them.

Cavernous hemangiomas are most frequently located in CNS subcortical tissue. Secondary sites include the pons and midbrain, basal ganglia, spinal cord and cerebellar white matter. It is estimated that one third of the cases seen are multiple with an average of four to five foci. In pathological specimens, there is a much higher incidence of hemorrhage associated with cavernous hemangiomas than with capillary telangiectasis.[1] Microscopic tissue examination, however, may reveal varying stages of posthemorrhagic organization with gliosis, calcification, and occasionally ossification, indicating a probable history of

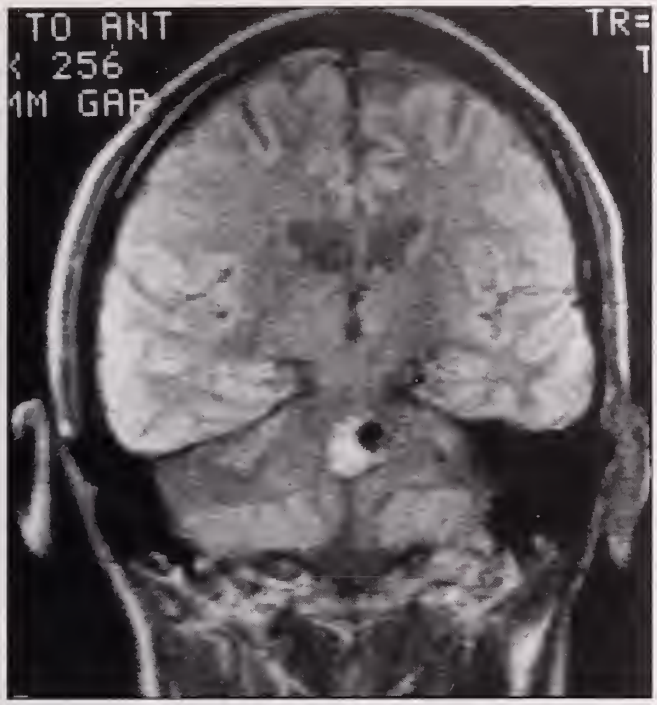

Fig. 5a

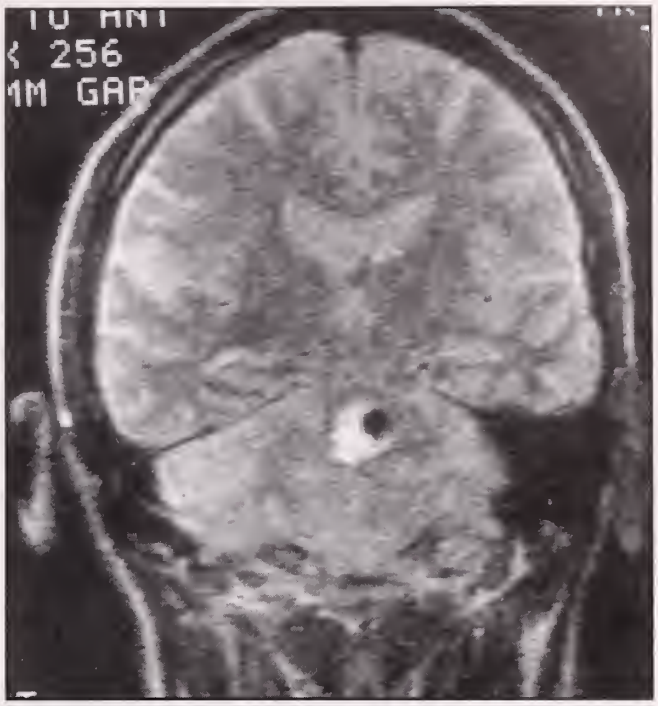

Fig. 5b

Fig. 5.—Coronal MRIs, T1 (5a) and T2 (5b) weighted, performed at outside hospital (on 0.35 Tesla Technicare unit) demonstrate bright signal region of methemaglobin with an eccentric dot of signal void representing hemosiderin in brainstem AVM. No calcifications were seen on CT.

prior multiple small hemorrhages.[1,6]

Arteriovenous malformations discovered in the pons or midbrain are, therefore, likely to be either capillary telangiectatic or cavernous in nature. Although these and the other two types of AVMs are commonly considered congenital in origin, separation from frankly vascular neoplasms can be difficult, even on a histological examination.[6] The symptoms and signs produced by all AVMs can result either from tissue destruction secondary to hemorrhage and compression from expanding vasculature or ischemia of adjacent tissue due to a "steal" effect.[1] In our series five of six patients presented with hemorrhage. One had a symptom complex consistent with ischemia (Case 3) and since he never had an MR examination, the definiate exclusion of hemorrhage has not been made.

The midbrain and pons are the crux of nerve fibres in a complex network as well as the location of a myriad of midbrain nuclei among the corticospinal, spinothalamic, and ponto-cerebellar fibre tracts. Even a small abnormality such as a microscopic vascular malformation could result in serious clinical deficits from hemorrhage or ischemia. As a consequence, symptoms most often noted in brainstem lesions involve cranial nerve palsies, usually marked by internuclear opthalmoplegia (Cases 2, 3, and 6), sixth cranial nerve palsy (Case 5), dysarthria, facial and limb sensory or motor deficits, and sometimes cerebellar ataxia. Reported findings of brainstem AVM with an associated paresis of vertical upward gaze with tonic deviation of the eyes downward and inward do exist but exact anatomic pathways to explain this are not clear.[7]

Symptoms of all types of intracranial AVMs usually manifest during young adulthood. In a study of 98 neurosurgical patients with all types of AVM in 1973, 54% were symptomatic prior to age 30 and 65% fell between ages 10 to 39 years.[4] Our six patients fit this pattern with four of them having onset of symptoms in this age group (Table 1), with the rare exception of Case 1 who was under one year of age. In some patients, cerebral AVMs of all types are discovered incidentally. In autopsy studies of 45 patients Teilman found 20% of 45 AVMs in all locations were completely asymptomatic according to medical records, and McCormick reported 50% of 164 cases as being clinically silent.[5,8]

Four-vessel cerebral angiography for diagnosis of brainstem cavernous or telangiectatic AVMs is believed to be inaccurate because of the high incidence of false negative examinations.[9] Servo et al in 1984 explained the inefficiency of cerebral arteriography by the small diameter of the feeding vessels, reduced rate of circulation, and presence of thrombi in the vascular elements of cavernous hemangiomas.[9] Diamond et all in 1976 supported this view claiming cavernous angiomas in all locations do not accumulate contrast media because they contain a reservoir of slowly filling vessels, resulting in a dilutional effect of the contrast

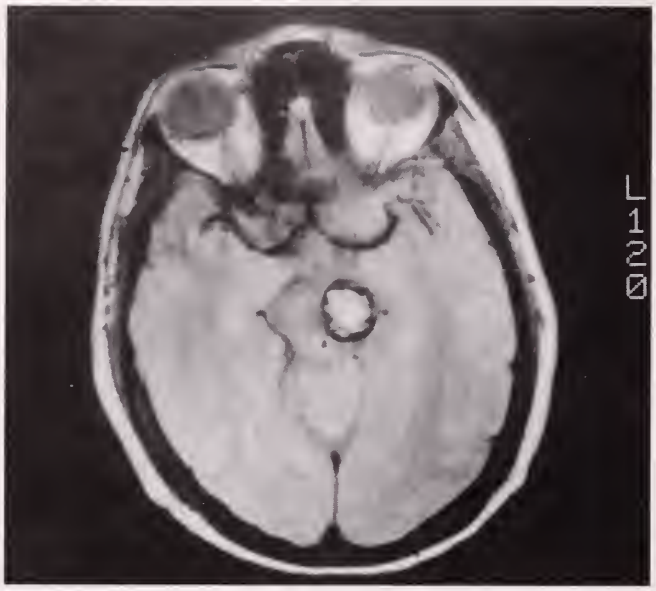

Fig. 6a

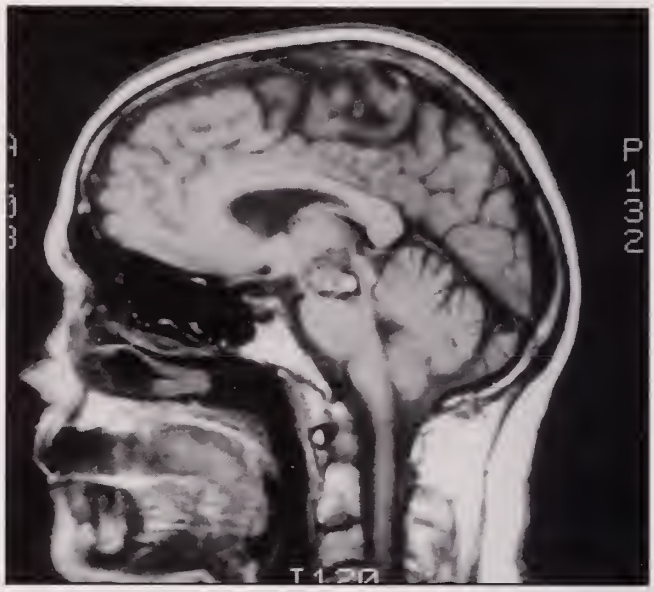

Fig. 6c

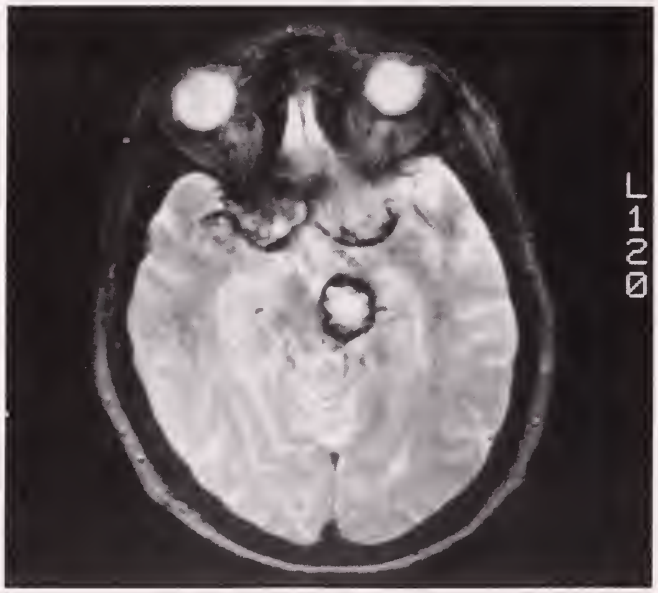

Fig. 6b

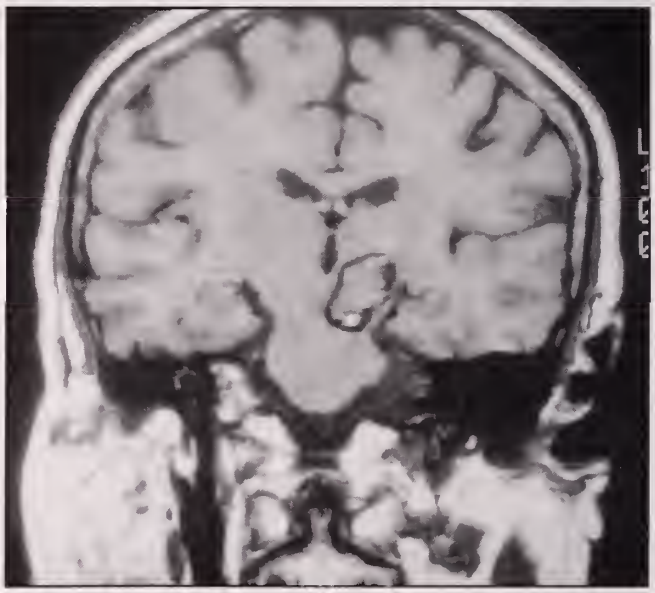

Fig. 6d

Fig. 6.—Axial T1 (6a) and T2 (6b) weighted MRI scans performed on GE Signa 1.5 Tesla machine plus sagittal T1 weighted (6c) and coronal T1 (6d) weighted images on the same patient demonstrate the characteristic findings of chronic hematoma within a brainstem AVM, including areas of loculated old blood (short T1 and long T2) and circumferential areas of signal void representing hemosiderin deposit. The 3 planes very nicely demonstrate the exact location of the lesion which was responsible for the right hemiparesis (left cerebral peduncle — right in the middle of the descending corticospinal tracts).

media.[10] Our data strongly support these opinions with negative angiograms in all six patients.

Computerized tomographic scanning was, until the advent of MR, the most accurate method of diagnosis of brainstem and all types of vascular malformations but still required a high index of suspicion and differentiation from tumor. Cavernous and telangiectatic angiomas can be visualized as hyperdense areas on plain CT due to the presence of calcium in vessels walls. The lesions enhance with intravenous contrast administration due to direct appearance of contrast within the dilated vessels and accumulation in adjacent abnormal brainstem tissue blood brain barrier. While acute hemorrhage might be easily identifiable to CT, subacute or chronic hemorrhage might be easily identifiable on CT, subacute or chronic hemorrhage would be isodense or hypodense with respect to normal brainstem tissue and might easily be overlooked, especially in very chronic situations where any mass effect has resolved.

The advent of MRI, however, has allowed reliable diagnosis of AVMs in general and difficult brainstem

Table 1

Case	Sex	Age	Presentation	Duration	Outcome
1	F	6 mo.	Difficulty swallowing	Approximately one month	Operated with some improvement
2	F	40	Sudden onset mild dysarthria, headache, left hemiparesis, internuclear opthalmoplegia	Sudden onset	Alive, symptomatic
3	M	35	Slowly progressive dysarthria, internuclear opthalmoplegia	15 years	Alive, symptomatic
4	F	24	Abducens palsy (4th cranial nerve deficit)	Sudden onset 3 years ago	Alive, symptomatic
5	M	43	Internuclear opthalmoplegia	Sudden onset 4 years ago	Alive, symptomatic
6	F	60	Right hemiparesis and left gaze palsy	Sudden onset 6 years ago	Alive, symptomatic

AVMs in particular. Because of the ability of MR to image in planes other than axial (sagittal and true coronal), abnormalities can be more readily localized to specific anatomical regions such as the brainstem, where beam-hardening artifacts can confuse diagnosis with CT. Because of inherently increased resolution and sensitivity with MR scanning better detection rates of smaller lesions are noted in this difficult to visualize area. Most important, however, is the ability of MR to accurately and reproducibly identify the presence of chronic hemorrhage within a lesion, as originally described by Gomori and Grossman et al in their original work with high-field strength MR imaging of the evolution of hematomas.[2] Due to the presence of blood breakdown products, notably methemaglobin, chronic blood has a characteristic bright signal on both T1 weighted and T2 weighted images. In addition, the eventual deposition of hemosiderin within the periphery or body of a hematoma cavity has its own characteristic appearance on MRI. Due to local field heterogeneities as well as a frank paramagnetic effect the iron-containing hemosiderin molecules cause a flow void or absence of signal which was recently noted in MRI examination in the presence of brainstem angiomas.[3] The presence of chronic blood and/or hemosiderin in a brainstem or basal ganglia location is cause to consider brainstem vascular malformations in the differential diagnosis. This in conjunction with a relatively benign course, even of sudden onset, would be strongly suggestive of brainstem AVM over tumor. Large area of flow void representing flowing blood in dilated arterial structures, as seen characteristically in other AVMs, are not seen in brainstem AVMs.

The treatment of choice of large or accessible cerebral vascular malformations is radical excision, but the risk must be weighed against the likelihood of initial or recurrent hemorrhage. Surgical removal is rarely possible in the brainstem or deep thalamic tissues where cavernous and telangiectatic AVMs are likely to occur but has been successfully performed as in Case 1 in our series.[3,9]. External beam radiation therapy with proton has shown some benefit mostly in sclerosing the AVM and promoting hyalinization of vessel walls and subsequent thrombosis. Some authors believe this sort of radiation to be the treatment of choice in brainstem AVMs but it remains controversial.[4]

In our series, all six patients survive with serious but stable deficits; therefore, we conclude that brainstem AVM may be associated with considerable morbidity but little mortality and is a devastating but not lethal lesion. Four of our patients are female, which is not in agreement with previously published reports of equal sex incidence for telangiectatic AVM's.[4] The onset of symptoms in two cases was prior to 40 years of age, with one six-month-old patient being, we believe, the youngest reported case of this abnormality. Five patients had sudden onset of symptoms related to hemorrhage as noted on MR (Table 1). Five patients experienced dysarthria and/or internuclear opthalmoplegia or abducens palsy, and three presented with unilateral hemiparesis, an indication of direct involvement or location of hemorrhage within cortiocspinal tracts running in the posterior limb of the internal capsule or cerebral

peduncles, midbrain, or pons. The six-month-old infant presented with swallowing difficulty, indicating involvement of cranial nerve 9, 10 and possibly 12 nuclei within the brainstem. This was confirmed by location of the hematoma on MR.

Conclusion ● The significance of this series lies in the demonstration of the MR appearance of these rare but important brainstem AVMs for which we have noted characteristic findings of chronic hemorrhage within the pons and midbrain. Diagnosis requires a high index of suspicion but the characteristic MR findings of chronic blood in the brainstem may be pathognomonic. Brainstem or thalamic telangiectatic malformations and cavernous hemangiomas should be included in the differential diagnosis of any patient with midbrain symptoms of either an acute or chronic nature and findings of calcifications or increased density on CT in midbrain or basal ganglia structures. MR findings of decreased T1 (bright signal) and increased T2 (bright signal) or areas of signal void which are known to represent chronic brainstem hematomas and hemosiderin deposition respectively are probably pathognomonic in the brainstem for these lesions. Although brainstem gliomas, metastases, or hamartomas must be included in the differential and, in fact, cannot really be excluded even on histological examination, lack of change of CT or MR findings with time or lack of mass effect may assist in the diagnosis of brainstem AVM. MR cannot differentiate cavernous hemangioma from telangiectasis at the present time, but then again neither can a well trained pathologist on histological examination in many instances.[6] This series emphasizes the importance and ability of making this diagnosis on imaging with the newer techniques of magnetic resonance.

References

1. Roberson, G.H.; Kase, C.S., and Wolpow, E.R.: Telangiectases and Cavernous Angiomas of Brainstem: Cryptic Vascular Malformations, Neuroradiology 16:83-89, 1974.
2. Gomori, J.; Grossman, R.; Goldberg, H.; Zimmerman, R., and Bilaniuk, L.: Intracranial Hematomas: Imaging by High-Field MR, Radiology 157:87-93, 1985.
3. New, P.; Ojemann, R.; Davis, K., et al: MR and CT of Occult Vascular Malformations of Brain, AJNR 7:771-779, 1986.
4. Pia, H.W.; Gleave, J.R.W.; Grota, E., and Zierski, J.: Cerebral Angiomas, Advances in Diagnosis and Therapy, Munich, Springer-Verlag, 1974, pp. 87-123
5. McCormick, W.; Hardman, J., and Boulter, T.: Vascular Malformations (Angiomas) of Brain, with Special Reference to Those Occurring in Posterior Fossa, Neurosurgery 26:241-251, 1968.
6. Rubenstein, L.J.: Tumors of Central Nervous Systems, Armed Forces Institute of Pathology, Washington, D.C., 1970, pp. 241-256.
7. Gilner, L. and Avin, B.: Reversible Ocular Manifestation of Thalamic Hemorrhage, Arch. Neurol. 13:715-716, 1977.
8. Teilman, K.: Hemangiomas of Pons, Arch Neurol. Psychiat. 14:208-223, 1953.
9. Servo, A.; Porras, M., and Raininko, R: Diagnosis of Cavernous Hemangiomas by Computerized Tomography and Angiography, Acta Neurochirurgica (Wein) 71:3-4, 273-282, 1984
10. Diamond, C.; Torvik, A., and Amundsen, P.; Angiographic Diagnosis of Telangiectases with Cavernous Angioma of Posterior Fossa, Acta Radiologica (Diagnostica) (Stockholm) 17:3; 281-288, 1976.

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Hemophilia and AIDS: the Community and the Pediatrician

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***ABSTRACT:** AIDS in hemophiliacs has altered the nature of a disease otherwise readily controllable with judicious blood product support. A thorough knowledge of the pathobiology of this disorder is a fundmental requirement for patients, their families and the community at large so as to enable physicians caring for patients often enveloped in a maelstrom of abusive and stigmatizing behavior to address all aspects of therapy objectively and compassionately.*

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Any individual with a serious illness is confronted by two problems: extent of morbidity and threat of fatality. For patients afflicted with human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS), a third and frequently even more overwhelming component is added, that of community awareness leading to stigmatization. Physicians may become pressured by their apparently conflicting responsiblities to the individual patient and to the community at large. Within this context, this report seeks to present accurate information about children with HIV infection designed to enable enlightened care to prevail over community fears and anxieties.

The care of hemophiliac children with AIDS provides the prototype for this report. They are the most common school age children afflicted with this disease, and pediatricians and pediatric hematologists have gained significant experience in caring for them. This information, moreover, is referrable to all children with HIV disease, be it transplacentally transmitted or acquired from intravenous drug abuse or sexual activity.

Natural history ● In brief, HIV infection in children falls into two categories: asymptomatic and symptomatic. A clinical staging system, derived from reports provided by the Communicable Disease Çenter in Atlanta[1] are detailed in Tables 1 and 2. In infants, diagnostic confusion may occur because of identification of an IgG antibody (the result of transplacental transmission). In effect, its presence alone cannot be the sole criteria for diagnosis of AIDS in children below 15 months of age. Culture positivity and/or detection of the antigen is required in order to obviate the misleading possibility of a passively transferred antibody. Overall, infants born to seropositive mothers have a 20-50% risk of the development of clinical disease.[2-4]

Table 1.—Summary of Definition of HIV Infection in Children.

Infants and children under 15 months of age with perinatal infection

1. Virus in blood or tissues or
2. HIV antibody and evidence of both cellular and humoral immune deficiency and one or more categories in Class P-2 or
3. Symptoms meeting CDC case definition for AIDS

Older children with perinatal infection and children with HIV infection acquired through other models of transmission

1. Virus in blood or tissues or
2. HIV antibody or
3. Symptoms meeting CDC case definition for AIDS

Table 2.—Summary of Classification of HIV Infection in Children Under 13 Years of Age.

Class P-0. Indeterminate infection
Class P-1. Asymptomatic infection

- Subclass A. Normal immune function
- Subclass B. Abnormal immune function
- Subclass C. Immune function not tested

Class P-2. Symptomatic infection

- Subclass A. Nonspecific findings
- Subclass B. Progressive neurologic disease
- Subclass C. Lymphoid interstitial pneumonitis
- Subclass D. Secondary infectious diseases
  - Category D-1. Specified secondary infectious diseases listed in the CDC surveillance definition for AIDS
  - Category D-2. Recurrent serious bacterial infections
  - Category D-3. Other specified secondary bacterial infections
- Subclass E. Secondary cancers
  - Category E-1. Specified secondary cancers listed in the CDC surveillance definition for AIDS
  - Category E-2. Other cancers possibly secondary to HIV infection
- Subclass F. Other diseases possibly due to HIV infection

In the small child or infant the symptom complex is essentially consistent with findings in patients who fail to thrive and have associated developmental delay. In such cases, the majority are symptomatic within the first two to three years of age and rapidly succumb once bacterial or other opportunistic infections supervene.

In older children, the clinical features of HIV infection are essentially identical to those observed in adults with AIDS or the AIDS-related complex (ARC), the only major clinical distinction being the unusual frequency of bacterial infections.[5] Following each infection, children tend to experience a variable period of symptomatic relief despite gradual deterioration of their immunologic status. Initially, a rash of bacterial infections occurs and then later, opportunistic infections, e.g., pneumocystis carinii and yeast, supervene.[6-14] Neoplastic diseases, particularly lymphoid malignancies, are attributable to the immune aberrations. A peculiar form of an immunologically mediated pneumonia, a lymphoid interstitial process, which may also involve the heart as well as the kidneys, liver and bone marrow may develop in children with AIDS. Overall, the clinical course is variable.

Epidemiology of AIDS in hemophilia and related disorders ● Information derived from the CDC covering the period 1/1/81 to 7/6/87 notes 374 cases of AIDS in patients with hemophilia and related bleeding disorders.[15] Hemophilia A (factor 8 defect) accounts for 334 or 90% of these cases, the remainder occurring essentially in patients with hemophilia B (factor 9 deficiency), with additional cases among patients with von Willebrand's and other clotting variants. Of this total 253 or 68% were classified as severe (those receiving numerous blood product transfusions). The frequency distribution is skewed in hemophilia A to those individuals 20 years of age and older. For example, of the entire 374 patients, 60 are in the 1-19 year old age group and 97 in the 40+ year age group. Two factors obviously play a role in this regard: (1) latency period for the disease and (2) decline in new cases attributed to heat treatment of the preparations. The decline in incidence was first noted in late 1987 and is projected to result in a 1988 incidence on the order of 50% of the number identified in 1987. It is notable that only the sexual partners of hemophiliac patients have experienced seroconversion. No cases of AIDS have been observed among the siblings or parents of these patients, reflecting the low communicability of this infection. As expected, the largest number of AIDS cases are found in those areas of greatest population density. Current demographics reveal two such fairly dense outcroppings, the largest in the states of New York, Pennsylvania, New Jersey and California followed in close order by Michigan, Ohio, Illinois, Iowa, Texas, Arizona, Virginia and Florida.

Laboratory diagnosis ● The most commonly used diagnostic method is the enzyme linked immunosor-

bant assay (ELISA test), which is a sensitive screening test and mandates, when positive on repeat study, confirmation by western blot examination. The latter utilizes the HIV proteins, which, following separation by electrophoresis, react with the test sera. As in other tests, the western blot is not infallible. Both false negative and positive results have been identified. Additionally the HIV virus can also be identified in culture systems or in systems which detect HIV antigens in sera or tissues. However, viral isolation is a slow and tedious process with false negatives often occurring 40-50% of the time.[16]

The AIDS virus (or viruses?) is biologically indistinguishable from all others in the retrovirus family. Initially it was referred to as the human T-cell lymphotropic virus or HTLV. Subsequent studies suggested use of the clinically more graphic descriptions, i.e., lymphadenopathy associated virus (LAV) or (by incorporating immunologic and clinical features), the immune deficiency associated virus (IDAV). The currently accepted terminology is the result of incorporating these into one term: human immunodeficiency virus (HIV), which satisfies the following criteria:[17]

1. Tropism for T-lymphocytes
2. Multinucleated giant cell inclusions
3. High molecular weight substance with high magnesium ion requirements and strong preference for reverse transcriptase
4. A relatively small major protein core.

The virus is especially labile and, on the laboratory bench, is inactivated within minutes; in contrast, the hepatitis B virus can remain alive on the laboratory bench for as much as one day.

Therapy ● There are as yet no unequivocally-proven, successful therapeutic endeavors.[18] A major limitation to anti-HIV therapy is the fact that agents currently undergoing testing inhibit only replicating but not latent phase cells. The most commonly used agent is azidodeoxythymidine (AZT), an inhibitor of reverse transcriptase, which is available as an oral preparation. Side effects, although common, are not serious and include anemia, leukopenia, headache and less frequently nausea. DDC (dideoxycytidine) is similar to but more toxic than AZT. Toxicity control trials are underway. Other investigational agents include suramin and HPA-23, also reverse transcriptase inhibitors. Because of severe toxicity consisting of bone marrow suppression and adrenal insufficiency, it is unlikely that either of these agents will reach major trials. Even less information is available regarding high-dose ribavirin (1-beta-D-ribofuranosyl-1, 2, 4-triazole-3-carboxamide), which like AZT, inhibits viral replication and for which ongoing trials continue. Peptide I blocks entry of HIV into CD-4 cells. It is nontoxic and undergoing Phase I studies. Larger studies are awaiting trials. Vaccine studies are yet too premature for meaningful information.

Support system ● No less significant than identifying a cause, while investigating therapeutic endeavors, is the need to comprehend by objective and explicit education activities the consequences of disease states. And these activities must, perforce, be addressed in the marketplace — be it at home, school, work, or church; and it should be addressed by comprehending, compassionate, and intelligent participants. All such information should be so presented as to ensure an open and constructive exchange of ideas. Thus, in addition to data presented in peer reviewed journals, timely and constructive information should be provided in the medical sections of respectable newspapers, magazines and in organizational publications involved in scientific data collection, specifically those published by the Public Health Service and the Centers for Disease Control, as well as the Hemophilia Information Exchange published by the National Hemophilia Foundation and underwritten by the United States Department of Health and Human Services (Office of Maternal and Child Health).

Most important, the physician, as healer and educator, must be well versed on the subject of AIDS and ready to participate in open and frank discussions with parents, patients, families and the community regarding school, work, family interactions, and sexual activity. The physician should be prepared to address social behavior in practical, knowledgeable and nonmoralizing terms. These issues are especially important within the context of the school-age patient. It is within the school setting that confusion and fear frequently coexist and here the physician can lend support to proper education regarding all ramifications of AIDS. Dissemination of such information should include the following recommendation:[19]

1. AIDS is difficult to transmit. The only known routes are via infected/contaminated blood products and/or needles and sexual contact. There are no data to support transmission via normal, casual or nonsexual contact in any setting.

2. Serum positivity for HIV does not necessarily mean that the patient has AIDS, and screening for AIDS prior to school attendance has no validity. Knowledge by school personnel that an "ill" person is in school is reasonable but not a prerequisite for school attendance.

3. Children with AIDS, unless debilitated, should be encouraged to attend school and receive all the privileges thereunto. Information that a school child has AIDS is privileged and cannot be violated unless approved by a legal guardian. No distinction should be made between day care and school attendance nor should toddlers be treated any different from school-age children.

4. Routine hygenic procedures are sufficient to dispose of bodily secretions, and cleanliness and proper disposal of blood letting material are necessary but no more so than when those procedures are carred out in the care of patients with hepatitis.

5. Sexually active partners, one of whom has AIDS or is seropositive but otherwise asymptomatic, should be made aware that condoms is the only (relatively) sure approach to control of sexually transmitted disease. However, no method is 100% effective.

6. The AIDS patient and family should always be aware of new developments into the nature of the disorder, be they epidemiological or bench research data.

7. AIDS patients should be encouraged to utilize all community activities intended to provide first class services when needed.

Once all the facts are known and placed in proper perspective, ostracism, relegation to second class status, untoward fear, and epidemics of panic should disappear from the scene.

And once all these issues are put to rest, the ultimate interaction that remains is the question of confidentiality. Confidentiality regarding the results of HIV antibody testing is one of the most controversial areas in medicine today. An issue of particular concern to pediatric hematologists is the rationale for screening hemophiliacs, who are at high risk because of their blood product exposure history. Many physicians order such tests, often after obtaining informed consent, both as a means of collecting epidemiologic data and more recently for baseline information prior to starting therapeutic trials. Many physicians have gone to great length, including establishment of separate nonhospital charts, in order to ensure confidentiality. At conflict toward these aims may be school boards, parents, and public health officials demanding knowledge in order to "assure the health of others." In order to address this major conflict, a useful approach is establishment of an utilitarian analysis reviewing the benefits in maintaining or eliminating confidentiality of HIV testing.

Benefits of confidentiality

1. Support of traditional doctor-patient rules of confidentiality which foster the patients' sharing of intimate aspects of their lives relevant to their medical care.

2. Research endeavors are best supported by an atmosphere of confidentiality. Much remains to be learned about HIV infections and AIDS and confidentiality about patient entry into, and results of, studies has long been assured. This is probably of greatest necessity in the surveillance studies but is equally important with the use of various therapeutic agents.

3. Notable examples of the abuse of HIV-infected hemophiliacs by their communities are well documented. Children have been kept away from school, taunted, and literally driven from their homes by a variety of hostile verbal and physical events.

Benefits of nonconfidentiality

1. It is argued that HIV-positive children must be identified in order to protect other children and/or school personnel. However, there is no documented risk to contact with such children and no medical basis for their exclusion from the school or workplace.

2. A *reductio ad absurdum* argument is raised regarding a retarded or perhaps autistic child who may bite, drool excessively, or scratch others. These patients can easily be handled by the involved physician on an individual basis and not as a general *cause celebre*.

3. The argument is made about bleeding by HIV-infected individuals. One is asked how school personnel protect themselves if they do not know that an individual is infected. The CDC and medical profession argue conclusively that all individuals need to be considered infectious and all blood exposures, irrespective of knowledge regarding the underlying disease, be treated with great care.

The arguments for confidentiality, therefore, tend to be humane, medically rational, and utilitarian. In short, historical and medical arguments for continued confidentiality remain valid.

In conclusion, this report is designed to provide insight into the nature of AIDS in children using hemophilia as the model. As stated so elegantly in the Report of the Surgeon General's Workshop on Children with HIV Infection and their Families: "It should become possible for AIDS to be considered with neither more nor less emotion than other severe illnesses of infancy and childhood. Key issues of AIDS epidemiology are poorly understood by most segments of society. A concerted community educational effort should be undertaken. Guidance and education programs developed with Federal support should be directed from national groups to their memberships, including health-care groups, education and parent groups, and social work groups."[19]

There is little likelihood that HIV infections will disappear as rapidly as they first appeared.[20] We do not know which method of treatment is best nor do we know whether or not a vaccine will soon be developed to control further cases. What we do know is that (1) the disease appears to be uniformly fatal, (2) the mechanisms of disease transmission are well defined, and (3) it is an illness that commands as much respect as it does attention, compassion and knowledge. In effect, so long as children with AIDS are able to function without impairment, they should be permitted to participate in community affairs on a basis equal to other members of the social and medical community.

References

1. Morbidity and Mortality Weekly Report 36:225, 1987.
2. Rubenstein, A and Novic, B.E.: AIDS: Predictive Perspective, AIDS 1:3, 1987.
3. Scott, G.B.; Fischl, M.A., Klimas, N., et al: Mother of Infants with Acquired Immunodeficiency Syndrome: Evidence for Both Symptomtic and Asymptomatic Carriers, JAMA 253:363, 1985.
4. Thomas, P.A.; Lubin, K.; Milberg, J., et al: Cohort Comparison Study of Children Whose Mothers Have Acquired Immunodeficiency Syndrome and Children of Well Inner City Mothers, Ped. Infect. Dis. 6:247, 1987.
5. Ruhenstein, A: Pediatric AIDS, Cur. Probs. Peds. 16:361, 1986.
6. Shelhamer, J.H.; Ognibene, F.P.; Macher, A.M., et al: Persistence of *Pneumocystis carinii* in Lung Tissue of Acquired Immunodeficiency Syndrome Patients Treated for Pneumocystis Pneumonia, Am. Rev. Respir. Dis. 130:1161, 1984.
7. Klein, R.S.; Harris, C.A.; Small, C.B., et al: Oral Candidiasis in High Risk Patients as Initial Manifestation of Acquired Immunodeficiency Syndrome, N Engl. J. Med, 311:354, 1984
8. Post, M.J.D.; Chan, J.C.; Hensley, G.T., et al: Toxoplasma Encephalitis in Haitian Adults with Acquired Immunodeficiency Syndrome: Clinical-Pathologic-CT Correlation, AJNR 4:155, 1983.
9. Macher, A.M.; Reichert, C.M.; Straus, S.E., et al: Death in AIDS Patient: Role of Cytomegalovirus, N. Engl. J. Med. 309:1454, 1983.
10. Quinnan, G.V.; Masur, H., Rook, A.H., et al: Herpesvirus Infections in Acquired Immunodeficiency Syndrome, JAMA 252:72, 1984
11. Kovacs,J.A.; Polis, M.; Macher, A.M., et al: Cryptococcus Infections in Patients with Acquired Immunodeficiency Syndrome (abstr 804). Abstracts of 24th ICAAC, Washington, D.C., American Society for Microbiology, 1984
12. Current, W.L.; Reese, N.C.; Ernst, J.C., et al: Human Cryptosporidiosis in Immunocompetent and Immunodeficient Persons, N. Engl. J. Med. 308:1252, 1983.
13. Gillin, J.S.; Urmacher, C.; West, R., et al: Disseminated *Mycobacterium avium-intracellulare* Infection in Acquired Immunodeficiency Syndrome Mimicking Whipple's Disease, Gastroenterology 85:1187, 1983.
14. Kovacs, A.; Forthal, D.N.; Kovacs, J.A., et al: Disseminated Coccidioidomycosis in Patient with Acquired Immune Deficiency Syndrome, West J. Med. 140:447, 1984.
15. Stehr-Green, J.K.; Holman, R.C.; Jason, J.M., and Evatt, B.L. Hemophilia-Associated AIDS in United States, 1981 to September 1987, Am. J. Pub. Health 78:439, 1988.
16. Ammann, A.J.: Human Immunodeficiency Virus Infections in Infants and Children, Adv. Ped. Infect. Dis. 3:91-110, 1988.
17. Devita, V.T.; Hellman, S., and Rosenberg, S., eds.: AIDS: Etiology, Diagnosis, Treatment, and Prevention, Philadelphia, J.B. Lippincott Co., 1985.
18. AIDS Update, Hemophilia Information Exchange, Med. Bulletin #61, Chapter Advisory #66, December 10, 1987, The National Hemophilia Foundation, The SOHO Bldg., 110 Greene St., Rm. 406, New York, N.Y. 10012.
19. AIDS Update, Hemolphilia Information Exchange, Med. Bulletin #59, Chapter Advisory #64, November 30, 1987, The National Hemophilia Foundation, The SOHO Bldg., 110 Greene St., Rm. 406, New York, N.Y. 10012.
20. Curran, J.W.; Jaffe, H.W.; Hardy, A.M.; Morgan, W.M.; Selik, R.M., and Dondero, T.J.: Epidemiology of HIV Infection and AIDS in the United States, Science 239:610-616, 1988.

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PROs: An Update

Paul W. Radensky, M.D.

The cost of health care has caused those paying for health services to devise ways to control what has seemed to be an intractable acceleration in charges. Chief among payors trying to control costs has been the federal government which supports services for the needy under the state-related Medicaid program and provides a massive insurance program for the elderly and those with end-stage renal disease under Medicare. Attempts at cost control have raised questions about effects on access to and the quality of health care delivered under these programs. When enacting legislation to control costs through the use of a prospective payment system for inpatient expenses under Medicare, Congress responded to these concerns by creating utilization and quality control peer review organizations (PROs) as watchdogs against program and patient abuses.[1]

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PROs were given responsibility for reviewing case histories, investigating patient or program abuses, and recommending sanctions (fines or exclusion from the program) against practitioners and providers who were determined to have "failed in a substantial number of cases substantially to comply with" or to have "grossly and flagrantly violated" obligations under the program.[2] Over the past few years PROs have been asked to focus on quality issues,[3] and the number of sanctions recommended by PROs has become a concern among physicians.[4] While some groups complain PROs are not being aggressive enough,[5] others argue that reviewing standards target unfairly rural and small town practitioners.[6] The government maintains PROs do not function under sanction quotas.[7] As of November 30, 1987 PROs recommended sanctions against 133 physicians to the Office of the Inspector General (OIG) of the Department of Health and Human Services (DHHS). The OIG approved sanctions against 82 practitioners: 24 were fined and 58 were excluded from Medicare for up to ten years.[8] These sanctions resulted from PRO evaluations of the quality of care provided by approximately 19,000 physicians about whom concerns were raised on initial reviews.[9] Only 5% of sanctions issued by the OIG are initiated through PROs, however. The bulk of OIG sanctions are the result of anecdotal reports presented to the OIG from patients and other physicians.[10]

PRO sanction process ● Health care providers' obligations under Medicare and sanctions for failure to comply with such are included under Section 1156 of the Social Security Act.[11] Regulations for enforcing the provisions of the statute are incorporated in Part 1004 of Title 42 of the Code of Federal Regulations, and further instructions are supplied in the Peer Review Organization Manual (PRO Manual) developed by the

Health Care Financing Administration (HCFA).

Under Section 1156 of the Social Security Act, providers furnishing health care services under title XVIII of the Social Security Act (i.e., the Medicare program) must assure: "that services or items ordered or provided . . .

(1) will be provided economically and only when, and to the extent, medically necessary;
(2) will be of a quality which meets professionally recognized standards of health care; and
(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities."[12]

The act further provides for imposition of fines or excluding from the program practitioners who have:

"(A) failed in a substantial number of cases substantially to comply with any obligation..., or
(B) grossly and flagrantly violated any. . .obligation in one or more instances."[13]

The statute provides for reasonable notice and opportunity for discussion between the practitioner and the PRO prior to the PRO's submitting a report and sanction recommendation to the Secretary of DHHS (i.e., via the OIG).[14] The procedures for providing such notice and opportunity are not specified in the statute. In addition, the act does not define "failed in a substantial number of cases substantially to comply" or "gross and flagrantly violated".

The regulations promulgated under the act define the statutory terms and outline what are the PRO's responsibilities but do not specify the scope of procedural guarantees afforded for meetings with PROs. Under the regulations, "'substantial violation in a substantial number of cases' means a pattern of care has been provided that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the PRO."[15] "Gross and flagrant violation" is defined: ". . .violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high-risk situations."[16] The regulations do not specify how many cases constitute "a pattern"; the PRO program manual indicates this is determined by the PRO on a case by case basis.[17] The manual gives examples to help PROs determine when violations have occurred.[18] The statute and corresponding regulations express a standard for evaluating physician conduct which differs from the "accepted professional practice" standard used for malpractice litigation. While the Medicare laws suggest that PRO sanctions are intended to protect beneficiaries against the most dangerous practitioners, the discretion left to PROs may mean physicians will be held to a higher standard for Medicare patients than for other patients.

The PRO sanction process is outlined briefly as follows. PROs may identify violations by examining a provider's practice, through case record review, or by referral from a PRO subcontractor, Medicare carrier or intermediary, HCFA or the OIG.[19] If the PRO determines that the practitioner has committed substantial violations, an initial notice is sent giving the practitioner 20 days to provide additional information or request a meeting with the PRO. At this stage the PRO and the provider may concur on a corrective action plan.[20] After this period, if the PRO determines that substantial violations have occurred or in the first instance, if the PRO has determined that a gross and flagrant violation has occurred, a 30 day notice is sent out (i.e., the second notice in the case of substantial violations and the initial notice in the case of a gross and flagrant violation). The provider has 30 days to submit additional information to the PRO or to request a meeting. After this round, if the PRO determines that a gross and flagrant violation or substantial violations have occurred, it submits a sanction recommendation, and informs the practitioner that she/he has 30 days to provide additional information to the OIG. In practice, the full PRO may make its determination on review of a recommendation made by a committee to which consideration of the case was delegated. There is no provision for a hearing at the OIG stage. The OIG has 120 days to act upon the PRO's recommendation. It may approve, reject, or modify the PRO's recommendation. In addition, for exclusion sanctions, if the OIG takes no action by the 120 day deadline, the sanction becomes effective automatically.[21] No sanction ever has been imposed under this self-executing provision of the law.[22] Under the statute, when the Secretary of DHHS (i.e., via the OIG) makes a determination to exclude a practitioner, the exclusion becomes effective upon reasonable notice to the public and the practitioner. The act does not call for a stay of the sanction or public notice pending administrative or judicial appeals.[23] Under the regulations, reasonable notice to the public is specified as publication in a newspaper of general circulation in the PRO area.[24] In addition, the regulations provide for notification to the following entities at the OIG's discretion: originating PRO, PROs in adjacent areas, state Medicaid fraud control units, state licensing authorities, Medicare contractors and state agencies, hospitals, skilled nursing facilities, home health agencies, HMOs, medical societies and other professional organizations, Medicare carriers and intermediaries, health care prepayment plans, and other affected agencies and organizations.[25] Post-determination administrative appeals include a hearing before an administrative law judge (ALJ) and discretionary review by an adminis-

trative Appeals Council. Following administrative review, an unsuccessful party can appeal to the courts.

Due process concerns ● Much controversy has centered on the procedures at the PRO stage concerning the implementation and public notice of sanctions prior to administrative and judicial appeals. Practitioners complaints have included: at the PRO stage — lack of right to legal counsel, an evidentiary hearing, or opportunity to call defense witnesses or to cross-examine PRO witnesses, lack of sufficient information concerning the data used by the PRO in making its determination, and inadequate time to prepare a response to the charges; at the OIG and sanction implementation stages — no provision for a hearing, implementation prior to completing administrative and judicial review, and harm resulting from publication of a sanction which would not be remediable at the appeals stage.[26] HCFA has acknowledged that sanctions are a "grave matter" and has explained its objective as balancing beneficiaries' interests in being protected from unfit physicians against fairness to physicians — their rights to adequate procedural protection when under threat of sanction.[27]

HCFA contends that a formal hearing before implementation of a sanction is not required by statute or under Supreme Court precedent.[28] The Peer Review Improvement Act of 1982[29] provides for administrative hearing and judicial reivew as granted under sections 205 (b) & (g) of the Social Security Act.[30] These sections do not require review prior to execution of a sanction.[31] HCFA asserts that the following procedures provide protection sufficient to satisfy the due process standards set forth by the Supreme Court:[32] the chance to meet with the PRO prior to its recommending a sanction (one meeting for gross and flagrant offenses and two meetings for substantial violations), the opportunity to submit additional written argument to the OIG before its determination, and the occasion for an evidentiary administrative hearing and judicial review after the sanction is effected.[33] The Court has held due process does not require a full evidentiary predetermination hearing.[34]

Responding to mounting pressure from practitioners, the American Medical Association (AMA) instituted suit against the DHHS in April, 1987 asking for an injunction against further processing of sanctions until changes were made in the PRO process.[35] In May 1987, the AMA, OIG, HCFA, and the American Association of Retired Persons (AARP) agreed upon the following improvements in the sanction procedures:

new model letters — PRO letters notifying practitioners of violations will explain the identified problem, the facts relied upon, the importance of meeting with the PRO, and the potential results of a sanction.

conflict of interest/bias — PROs will insure that no physician member of a panel recommending a sanction to the OIG has personal bias against or is in direct economic competition with the subject physician. In addition, PRO reviewing physicians responsible for developing initial findings will not vote on the PRO's final determination recommending a sanction.

procedures for the 30 day meeting —

- the meeting is to be held 30 days after practitioner requests (may be extended for good cause);
- the physician may have an attorney present who may make opening and closing remarks, ask clarifying questions, and assist with the presentation of expert witnesses;
- a transcript of the meeting will be made and will be available to the physician (and will be submitted to the OIG in the event of a sanction recommendation[36]);
- at the PRO's discretion, the physician may provide additional relevant information to the PRO within five working days after the meeting;
- provider will have the opportunity to present expert testimony in oral or written form on the medical issues presented; to aid preparation, the practitioner may disclose patient records to expert witnesses;
- recognition that it may be helpful to have present at the meeting the reviewing physician who developed the record and initial findings; this is left to the discretion of the PRO. (*N.B.:* there is no right to discover the qualifications of the reviewing physician, and there is no formal discovery of the basis of the reviewing physician's findings beyond the explanations provided in the PRO's letter.)

public notice alternative — OIG and HCFA will propose changes in the regulations giving practitioners the option of informing their patients that they have been excluded from the Medicare program rather than facing notice by publication.[37]

ALJ hearing process — HCFA and OIG will clarify that under current regulations an ALJ may accept any relevant evidence offered by a provider regardless of its having been presented to the PRO or the OIG. In addition, HCFA and the OIG will review ways to shorten the ALJ hearing process.[38]

The provisions for new model letters, protection against bias, and changes in the procedures for the 30 days meetings have been included in the revised Peer Review Organization Manual[39] and became effective May 12, 1987.[40] New regulations authorizing the alternative to notice by publication are being developed.[41] While the AMA was a partner to the agreement under which these changes were developed, the organization has continued to follow the issue closely.[42,43]

Statutory and case law developments ● In addition to regulatory changes in the program, Congress and the courts have become involved with attempts to improve the procedural fairness of the system. Once again in 1987, as part of its annual budget reconciliation process, Congress amended the PRO provisions of the Social Security Act. A preexclusion hearing before an ALJ has been added for practitioners located in rural health manpower shortage areas or counties with population less than 70,000. If the ALJ fails to determine by a preponderance of the evidence that a practitioner's continued furnishing of care to beneficiaries would pose a "serious risk" to such individuals, the exclusion will be stayed pending a full administrative hearing.[44] The term "serious risk" is not defined. Congress also included the following amendments to the PRO program: requiring a physician from the PRO to meet with medical and administrative staff of hospitals concerning the PRO's review of hospital services,[45] requiring the PRO to publish at least annually a report describing types of cases in which the PRO frequently found inappropriate or unnecessary care,[46] emphasizing the importance of educational activitites (concerning the review process and criteria applied) among PRO functions,[47] and requiring the PRO to take into account special problems associated with the delivery of care in remote, rural areas and other appropriate factors which could affect adversely the safety or effectiveness of treatment provided on an outpatient basis.[48] In addition DHHS is required to report to the Congress within one year on the improved procedures for imposing sanctions established under the agreement by the HCFA, AMA, AARP, and OIG.[49]

Under the recently enacted Medicare and Medicaid Patient and Program Protection Act of 1987,[50] physicians may be excluded from participation under the Medicare and Medicaid program for a variety of offenses. The act requires the exclusion of practitioners convicted of criminal offenses related to the delivery of services under Medicare or a state health care program or convicted of offenses related to patient abuse or neglect. In addition, the law permits the exclusion of providers under a number of circumstances including: conviction for participating in or interfering with the investigation of health care fraud, conviction for controlled substance abuse offenses (but not simple possession of such substances), suspension or revocation of state health care license, claiming excessive charges, furnishing items substantially in excess of patient needs, providing service that is of a quality which fails to meet professionally recognized standards (PROs will be responsible for assessing quality of care), and defaulting on health profession education loans.[51]

Since the PRO sanction program is relatively new there has been little development in the case law. A few recent federal district court cases and one administrative hearing determination suggest that major changes could be effected through appeals of adverse PRO determinations. In Greene v. Bowen[52] the court granted injunctive relief against exclusion or public notice of exclusion. The court concluded that implementation of the sanction prior to a hearing on the matter of whether the PRO applied appropriate standards of evaluation would cause the practitioner irreparable harm. The court did not review the correctness of the PRO's medical determination, however, and the injunction was tailored by requiring the physician to conform his practice to meet the PRO's concerns.[53] Similarly, a federal court in Maine enjoined enforcement or publication of a sanction where the court determined that the PRO did not base its decision upon regulatory criteria. Here again the court did not rule on the merits of the PRO's determination.[54]

In one of the first cases completing the initial level of administrative appeals, an ALJ rejected a PRO's findings of gross and flagrant violation and reversed a fine imposed by the OIG. While the judge concluded that the practitioner's care was substandard in some respects, he determined that such did not place the patient in imminent danger. In addition, the ALJ refused to admit in evidence testimony of the PRO chief supporting the government's case because the ALJ inferred that introduction of such testimony would present the appearance of bias. DHHS intends to appeal the case to an Appeals Council (the next level of administrative appeal).[55]

In addition to due process concerns, several related issues have been raised by physicians concerning the Medicare PRO program. Rural and small town physicians have argued that the review process unfairly targets their practices for sanctions.[56]

A rural health caucus has formed in Congress to develop a legislative response to these and other concerns about access to health care in rural areas.[57] The AMA also has been concerned about the rural-urban disparity. In addition the AMA has focused on the following issues: generic quality screens used by PROs, PRO reliance on punitive actions rather than on physician education, notification of patients about denials of payment based upon quality of care prior to allowing any appeal of such determination, and allowing practitioners and providers access to administrative and judicial appeals for payment denials (at present this is available only to beneficiaries).[58]

Comment ● Policing those who practice medicine is no easy task. What is good clinical practice must be determined under the unique circumstances presented by a given patient at a specific time. Translating good practice into standards and criteria for review by a third party is difficult at best; on a large scale the task may seem insuperable. In addition, cost containment has become an important consideration in health care. It is vital that quality care is not compromised by the financial constraints imposed. Some form of peer review must be developed which is

acceptable to practitioners and meets consumer needs. As is true for Medicare as a whole, the PRO program has undergone rapid, significant change and continues to evolve. Growing pains are expected. The PROs' scope of work, criteria for reviewing patient care, and procedures by which PROs carry out their statutory functions are dynamic. This period of change coupled with the split of oversight for Medicare among three congressional committees has made it difficult for practitioners to understand what are the roles of PROs and what is to be the relationship between PROs and providers. Congress, HCFA, OIG, professional organizations, consumer groups, and the courts are working to make the program meet its dual objectives of protecting patients and treating physicians fairly.

It is important for physicians to become aware of the PRO process and what it means to their practices. Medical charts need to document the quality of care provided. If faced with a sanction notice, a physician must recognize the seriousness of the charge and should seek counsel to assist with preparing an adequate defense against the charges.

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References

1. Peer Review Improvement Act of 1982 of the Tax Equity and Fiscal Responsibility Act of 1982, 42 U.S.C.A. secs. 1320c-c12 (West 1983).
2. 42 U.S.C.A. secs. 1320c-5(b)(1)(A)-(B) (West 1983).
3. PROs, licensing boards must sanction more MDs, consumer group urges, Am. Med. News, May 8, 1987, at 57, col. 1, col. 2.
4. E.g., AMA fights PRO sanction process, Am. Med. News, Apr. 24, 1987, at 1, col. 1.; PRO sanction boom matches MD resentment, Am. Med. News, Jan. 2, 1987, at 5, col. 1.
5. PROs, licensing boards must sanction more MDs, consumer group urges, supra note 3, at 57, col. 1.
6. E.g., Texas MDs concerned over PRO sanctions, Am. Med. News, July 24, 1987, at 27, col. 1; Small-town MDs allege harassment from PROs, Am. Med. News, Apr. 10, 1987, at 1, col. 1.
7. HHS vows changes in PRO physician-sanction process, Am. Med. News, May 15, 1987, at 1, col. 1, 66, col. 4.
8. Medicare PROs keep eye on MDs, quality of care, Am. Med. News, Jan. 1, 1988, at 31, col. 1.
9. Id.
10. Kusserow: If you commit fraud this man wants you, Med. World News, Apr. 27, 1987, at 51, 54.
11. 42 U.S.C.A. sec. 1320c-5 (West 1983).
12. 42 U.S.C.A. sec. 1320c-5(a) (West 1983).
13. 42 U.S.C.A. sec. 1320c-5 (b)(1) (West 1983)
14. Id.
15. 42 C.F.R. sec. 1004.1(b) (1986).
16. Id
17. Health Care Financing Administration, Peer Review Organization Manual pt. 6, sec. 6010 B (rev. 6 Octoher, 1985) (hereinafter PRO Manual) (PRO judgment in documenting substantial violations).
18. PRO Manual pt. 6, sec. 6005 (rev. 6 October, 1985) (identification of potential violations); *see* PRO Manual exhibit 4 (rev. 6 October, 1985) (synopsis of cases for 30 day letter (substantial number of cases only)); PRO Manual exhibit 6 (rev. 6 October, 1985) (synopsis of cases for 30 day letter (gross and flagrant violations only)).
19. PRO Manual pt. 6, sec. 6005 (rev. 6 October, 1985).
20. PRO Manual pt. 6, sec. 6015 B (rev. 6 October, 1987) (allowing a period for corrective action).
21. 42 U.S.C.A. sec. 1320c-5(b)(1) (West 1983).
22. Kusserow: If you commit fraud this man wants you, Med. World News, supra note 10, at 54.
23. 42 U.S.C.A sec. 1320c-5(b)(2) (West 1983). This section was amended by the Omnibus Reconciliation Act of 1987 to provide for a hearing before an administrative law judge (ALJ) prior to exclusion of practitioners located in rural health manpower shortage areas or counties with population less than 70,000. Omnibus Budget Reconciliation Act of 1987, 100th Cong., 1st Sess., 205 Cong. Rec. H12143 (daily ed. Dec. 21, 1987) (to be codified at 42 U.S.C. sec. 1320c-5(b)).
24. 42 C.F.R. sec. 1004.100 (d) (1986).
25. 42 C.F.R. sec. 1004.100 (e) (1986).
26. Appeal of sanction determinations — due process concerns, Medicare & Medicaid Guide (CCH) para. 12880.06 (1985) (excerpt from "Analysis and Response to Comments" from the preamble to the PRO sanction regulations by HCFA).
27. W. Roper, From the HCFA Sanctions Against Physicians, 258 J. A.M.A. 747 (1987).
28. Appeal of sanction determinations — due process concerns, supra note 26.
29. 42 U.S.C.A. secs. 1320c-c12 (West 1983).
30. 42 U.S.C.A secs. 405(b), (g) (West 1983).
31. Appeal of sanction determinations — due process concerns, supra note 26.
32. Mathews v. Eldridge, 424 U.S. 319 (1976).
33. Appeal of sanction determinations — due process concerns, supra note 26.
34. Mathews v. Eldridge, 424 U.S. at 335.
35. AMA fights PRO sanction process, supra note 4, at 1, col. 2.
36. Telephone interview with Public Affairs Office, Office of the Inspector General, DHHS (Aug. 27, 1987).
37. The timetable for proposing new regulations covering sanction notifications had not been determined as of Oct. 21, 1987. Telephone interview with Public Affairs Office, Office of the Inspector General, DHHS (Oct. 21, 1987).
38. Changes in the PRO Sanction Process, Medicare & Medicaid Guide (CCH) para. 36,300 (1987).
39. PRO manual (rev. 15 May, 1987).
40. Telephone interview with Office of Medical Review, Health Care Financing Administration, DHHS (July 8, 1987).
41. Roper, supra note 27, at 747.
42. AMA holds repeal threat in reserve on PROs, Am. Med. News, July 3-10, 1987, at 3, col. 1.
43. Id.; AMA's PRO Patience Fraying, Med. World News, July 27, 1987, at 22.
44. Omnibus Budget Reconciliation Act of 1987, 100th Cong., 1st Sess., 205 Cong. Rec. H12143 (daily ed. Dec. 21, 1987) (to be codified at 42 U.S.C. sec. 1320c-5(b)).
45. Omnibus Budget Reconciliation Act of 1987, 100th Cong., 1st Sess., 205 Cong. Rec. H12143 (daily ed. Dec. 21, 1987) (to be condified at 42 U.S.C. sec. 1320c-3(a)(6)).
46. Id.
47. Omnibus Budget Reconciliation Act of 1987, 100th Cong., 1st Sess., 205 Cong. Rec. H12143 (daily ed. Dec. 21, 1987) (to be codified at 42 U.S.C. sec. 1320c-2(c)).
48. Omnibus Budget Reconciliation Act of 1987, 100th Cong., 1st Sess., 205 Cong. Rec. H12143 (daily ed. Dec. 21, 1987) (to be codified at 42 U.S.C. sec. 1320c-3(a)(6)).
49. Omnibus Budget Reconciliation Act of 1987, 100th Cong., 1st Sess., 205 Cong. Rec. H12143 (daily ed. Dec. 21, 1987).
50. Pub. L. No. 100-93, Medicare & Medicaid Guide (CCH) No. 530 (Aug. 14, 1987) (signed by the President Aug. 18, 1987).
51. Id.
52. 639 F. Supp. 554 (E.D. Cal. 1986).
53. Id.
54. Doyle v. Bowen, 660 F. Supp. 1484 (D. Maine 1987) (the court noted, however, that the notice and hearing provided under the PRO procedures comported with the requirements of due process).
55. U.S. appealing decision overturning PRO ruling, Am. Med. News, Aug. 28, 1987, at 6, col. 1.
56. Texas MDs concerned over PRO sanctions, Am. Med. News, July 24, 1987, at 27, col. 1; Small-town MDs allege harassment from PROs, Am. Med. News, Apr. 10, 1987, at 1, col. 1.
57. Rural caucus formed for Medicare reforms, Am. Med. News, May 8, 1987, at 2, col. 1; Rural representatives urge changes in PRO process, Am. Med. News, May 8, 1987, at 55, col. 1 (discussing H.R. 2116).
58. American Medical Association, Handbook 1987 Annual Meeting of the House of Delegates (June 21-25, 1987).

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Suicide Prevention Update: Thirty Years Later

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***ABSTRACT:* Extensive efforts of the past 30 years have not reduced the incidence of suicide in the United States. Prevention centers provide valuable services in crisis intervention but this is not prevention in an epidemiological sense. Completed suicide is rare. Attempts and threats are much more common and carried out by a different population although there is some overlapping. We can identify groups that are at high risk but cannot predict which individual will commit suicide. Suicide intent scales in current use lack sufficient specificity and sensitivity to be useful. The majority of patients who attempt suicide suffer from depressions of all types, alcoholism and schizophrenia. They are more likely to visit physicians than suicide prevention centers. Heightened awareness of the suicide potential of these patients provides physicians with opportunities to make significant contributions to prevention.**

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For the past 30 years, suicide prevention has attracted ever-increasing interest in the United States. Major impetus for this movement came from the establishment of the Los Angeles Suicide Prevention Center in 1958 and a few years later of the Center for Studies in Suicide Prevention at NIMH chaired by Edwin Shneidman.[1] Since then much has been done. Many research studies have been carried out, valuable demographic and clinical data collected, a national organization with 1,200 members (American Association of Suicidology) devotes its efforts to this subject, and more than 200 suicide prevention centers are in operation in all parts of the country. In spite of these developments, some authorities are critical of what has been accomplished.[2-4] They point out that the incidence of suicide has not decreased. Since 1958 there has been a steady increase in the rate until 1978 when it leveled off. Since then it has remained at 12.2 per 100,000 per year; a reduction in the rate for people over 55 has been offset by a significant increase in the 15-24 age bracket.[5-7] The objective of this presentation is to review what has been done in the past three decades and to examine what opportunities exist for more effective suicide prevention.

Clinical aspects ● Suicide behavior includes attempts and ideation (threats) as well as completed suicides.[8] Individuals who commit suicide are, for the most part, psychiatrically ill. In three landmark studies, each involving 100 or more suicides, the leading diagnostic category was depressive illness or affective disorder, depressed phase.[9-11] Since these studies were completed before DSM-III, the nomenclature does not correspond exactly with diagnoses in current use. Today, they would be called major depression, bipolar disorder and dysthymic disorder. The second most frequent psychiatric disorder is alcoholism, i.e., alcohol abuse/dependence. Approximately two thirds of all

suicides fall into one or the other of these two groups.

The third most frequent disorder associated with suicide is schizophrenia. While the incidence varies considerably in different studies, there is widespread agreement that schizophrenics constitute a very high risk group.[12,13] Miles estimates that 10% of schizophrenics ultimately die by suicide, approximately 3,800 each year in the United States.[14] Other disorders associated with suicide include organic brain syndrome, various personality disorders and substance abuse. In all studies, 2-7% of suicides were without evidence of mental illness and are presumed to be well.

Attempters represent a different and much larger population than suicides. They are younger, peak rate is in the 20-24 year bracket, females predominate by ratios of 2:1 to 3:1 and overdose/poisoning is the most common method rather than firearms.[15] Attempters also include more personality disorders than completed suicides. Even though these are distinct populations, there is some overlapping in both directions: 1-2% of attempters do commit suicide each year and a significant percentage of eventual suicides have made previous attempts.[16,17] Since many attempts are not reported, and few are accurately described, the data on attempts are not entirely reliable.

Shneidman would restrict the term "attempted suicide" to: "the rare cases of lethal intention in which the individual, against all ordinary odds, fortuitously survives."[18] Those who make an attempt with an active method, leave notes and make minimal provision for rescue, do constitute one of the highest risk groups: almost 6% of them did commit suicide in the year following the attempt.[19] These individuals deserve the highest priority on the resources of the agency or practitioners treating them.

Most attempts are not made with such lethal intent. There is widespread agreement among clinicians that while attempts and threats are important from a psychodynamic viewpoint, the majority of these individuals are not intent on killing themselves. British psychiatrists have introduced the term "parasuicide" to replace the more ambiguous "attempted suicide."[20]

In addition to the underlying psychiatric disorder, certain events regularly precipitate suicides, or attempts, in vulnerable individuals. These usually involve loss of some kind: death of a friend or relative, disruption of a marriage, financial reverses, business failures, unemployment or legal difficulties.[6,15] In the case of teenagers who are impulsive and suggestible, "clusters" of suicides may occur in imitation of classmates who ended their own lives or may be precipitated by television programs about suicide.[21,22] Special mention should be made of two other periods of increased risk: loss of a therapist for any reason and the period following discharge from a psychiatric hospital.[23]

Prediction ● The majority of suicides give warnings of their intent, although these communications are often difficult to interpret.[24,25] "Verbalization of suicidal ideation or intent bears little relationship to the extent of the wish to die" and "(verbalization) may be a manifestation of personal style rather than an index of despair."[25] In order to prevent suicide we need to be able to identify the person who will take his own life unless he receives appropriate help. However, prediction presents many difficulties. From demographic and clinical data, we can recognize that certain individuals belong in a high risk group, but "the identification of the particular persons who will commit suicide is not currently feasible."[26] Researchers have worked for many years on suicide intent or hopelessness scales with which to estimate the degree of risk with more precision.[27-30] While they are useful for investigative purposes, they lack sufficient sensitivity and specificity to be of much value clinically. As an illustration: when the cutoff point on the Beck Hopelessness Scale is set so that it correctly identifies 90% of the suicides, it will yield 88% false positives.[31] The fundamental problem with prediction is that suicide is a rare event and "the statistical properties of rare events dictate that it will be extremely difficult, if not impossible, to identify those at risk with any degree of precision against the background of normality."[32] A further difficulty is presented by those who give no warning at all: they no longer complain, no longer seek help and confide in no one. As Havens expresses it: "the patient is going it secretly alone."[33]

Prevention ● There are three basic approaches to suicide prevention.[26] The first is to physically restrain the patient, e.g., hospitalization under suicide precautions. This is the usual approach with patients evaluated as a high risk for the near future. Hospitalization does provide the greatest safety over the short term even though in rare instances suicides do occur in psychiatric hospitals.[34] In actual practice there are limits to the number of patients who can be kept under such precautions in any institution. However, the major drawback is that it is demeaning and infantilizing of patients and casts the hospital staff in the role of adversary. This may interfere with the goals of long-term treatment and, as previously mentioned, the patient is at increased risk when he is discharged from the hospital.

The second approach to prevention is to relieve or remove the condition which produces the distress that is driving the individual to suicide. If this is a psychiatric illness, the psychiatrist can usually provide considerable help. Psychiatric treatment includes psychotherapy, antidepressants, lithium and electroconvulsive treatment, as indicated. If the distress involves personal, marital, or financial problems, then family members, friends or community may be able to provide appropriate help. The third approach is the most difficult of all: to raise individuals with such

healthy self-esteem that they will not perceive of suicide as a solution to their problems in living. This last approach, idealistic as it is, conforms most closely to primary prevention in an epidemiologic sense.[35]

Activities of suicide prevention centers ● At the forefront of efforts at prevention are the suicide prevention centers now operating in all parts of the country. Modeled after the pioneer Los Angeles Center, they are staffed by lay volunteers who receive training and supervision from mental health professionals. These centers maintain telephone service 24 hours a day, seven days a week. Any individual may phone the center and receive immediate attention. After listening to the problem, the volunteer counselor usually refers the client to an appropriate agency in the community, advises him to visit the crisis clinic at the center, or recommends some other appropriate action. Some centers have teams that visit families where a suicide has occurred, or has been attempted. Many centers are involved in educational activities in schools, churches, and other institutions.

The Los Angeles Center also has an outreach service called "Continuing Relationship Maintenance" that provides regular supportive contacts with high risk clients for many months.[4] This was modeled after the Samaritan Movement in Great Britain where it apparently has had some success.[36] So far benefits of the Los Angeles program have not been evident and it is a difficult program to maintain. Litman and Wold report that: "Chronically suicidal patients are so needy, dependent and demanding that they easily exhausted the energy and goodwill of friend, family and therapists."[4]

Suicide prevention centers provide valuable services to the community but these are in crisis intervention and not prevention. Some centers have changed their names to Crisis Centers in acknowledgment of their major function.

The majority of clients are not suicidal. The centers operate primarily in a passive mode: waiting for the individual in distress to make the first contact. There is no statistical evidence that they have reduced the suicide rate in the communities they serve. Kiev and Lester feel that individuals who are determined to kill themselves do not call these centers.[2,3] This probably is not entirely true since some studies show that about 2% of suicides have made contact with the centers prior to taking their lives.[37,38] Many clinicians feel that crisis intervention provides considerable help for the suicidal individual in an emergent situation although it is difficult to determine when a suicide has been actually prevented. There is a broad consensus that suicide prevention centers are not effective with the chronically suicidal individual who has exhausted all his resources and has lost hope. With this individual, crisis intervention postpones rather than prevents suicide.[4]

The physician's role ● According to many studies, approximately 50% of suicides consulted physicians in the month before their death.[9-11] These were predominantly nonpsychiatrists. This is a far higher percentage than called on suicide centers and points up the opportunities for prevention in physicians' offices. Clinical diagnosis is the key to effective treatment. Heightened awareness of the suicide potential and adequate treatment of patients with depression, alcoholism and schizophrenia may be lifesaving. Consultation with psychiatrists may result in more precise diagnosis, effective use of pharmacologic agents and more appropriate psychotherapy with these difficult patients.

Some clinicians feel that depression is frequently treated inadequately; that not enough use is made of lithium and ECT.[32] Not all suicides can be prevented but the physician has the responsibility to make a careful diagnostic evaluation and recommend (urge) appropriate treatment. Murphy feels that the physician's office deserves to be called the "primary prevention center."[32]

Discussion ● The extensive efforts of the past 30 years have not reduced the incidence of suicide in the United States. Suicide prevention is a very popular but misleading term, most of the activities so designated are really crisis intervention. Suicide prevention centers provide valuable services but they have not decreased the incidence of suicide in the communities they serve. Most of their clients are not suicidal. If the role of these centers has been overemphasized, the physicians' role in suicide prevention has been underemphasized. Many more suicides consult physicians prior to ending their lives than apply to any agency. Physicians, predominantly nonpsychiatrists, have opportunities to make important contributions by recognizing the suicidal potential in patients with depression, alcoholism, and schizophrenia. Diagnosis is the key to effective treatment and physicians are better equipped to do this than volunteers or lay mental health personnel. Collaboration between psychiatrists and physicians in other disciplines would be extremely helpful in the management of these problem patients.

The majority of individuals who make attempts, or threats, do not commit suicide. However, they are a source of endless disquiet to the physicians responsible for their care because a few of them do. We can recognize those at high risk but cannot predict which individual will take his own life. All suicide intent scales currently available lack sufficient sensitivity and specificity to be clinically useful. No community has the resources to provide comprehensive care to all suicidal individuals. The greatest shortage is in experienced psychotherapists to treat chronically suicidal individuals. The highest priority should be given to those who have made serious previous attempts as defined by Shneidman[18] and those with diagnoses associated with the highest risks.

Hospitals and psychiatrists have been sued

successfully even when all safeguards have been taken to prevent suicide. While the courts recognize that "emotional states cannot be calibrated with precision," they do vary considerably in their opinions as to what circumstances make a suicide "reasonably forseeable."[39] The physicians can only make careful diagnoses, recommend appropriate treatment and keep careful records. An interesting sidelight is that suicide prevention centers carry no liability insurance and their legal problems are "almost non-existent."[40] There is also great need for more prospective studies which yield more useful data to the clinician than do retrospective studies. However, as Lester points out, such studies present formidable difficulties and probably would only be feasible as a conjoint project carried out by several institutions.[3]

References

1. Shneidman, E.S. and Farberow, N.L.: Feasibility of Los Angeles Suicide Prevention Center, in Psychology of Suicide, edited by Shneidman, E.S.; Farberow, N.L., and Litman, R.E., New York, Science House, 1970.
2. Kiev, A.: New Directions for Suicide Prevention Centers, Am. J. Psychiat. 74:87-88, 1970.
3. Lester, D.: Myth of Suicide Prevention, Compr. Psychiat. 13:555-560, 1972.
4. Litman, R.E. and Wold, C.I.: Beyond Crisis Intervention, in Suicidology: Contemporary Developments, edited by Shneidman, E.S., New York, Grune & Stratton, 1976.
5. Weed, J.A.: Suicide in United States, 1958-1982, in Mental Health, United States, 1985, edited by Taube, C.A. and Barrett, S.A., NIMH, DHHS Pub # 85-1378, Washington, D.C. 1985.
6. Jocobs, D.: Epidemiology of Completed Suicides. Paper presented at symposium on suicide, Harvard Medical School-Cambridge Hospital, Boston, Feb. 1, 1985.
7. Sainsbury, P.: Epidemiology of Suicide, in Suicide, edited by Roy, A., Baltimore, Williams and Wilkins, 1986.
8. Pokorny, A.D.: Scheme for Classifying Suicidal Behavior, in Prediction of Suicide, edited by Beck, A.T.; Resnick, H.L.P., and Lettieri, D.J., Bowie [Md], Charles Press, 1974.
9. Robins, E.; Murphy, G.E.; Wilkinson, R.H. Jr., et al: Some Clinical Considerations in Prevention of Suicide Based on Study of 134 Successful Suicides, Am. J. Pub. Health 49:888-899, 1959.
10. Dorpat, T.L. and Ripley, H.S.: Study of Suicide in Seattle Area, Compr. Psychiat. 1:349-359, 1960.
11. Barraclough, B.; Bunch, J.; Nelson, B. et al: A Hundred Cases of Suicide: Clinical Aspects, Br. J. Psychiat. 125:355-373, 1974.
12. Pokorny, A.: Suicide Rate in Various Psychiatric Disorders, J. Nerv. Ment. Dis. 139:499-506, 1964.
13. Wilkinson, G.: Suicide Ratein Schizophrenia, Br. J. Psychiat. 140:138-141, 1982.
14. Miles, P.: Conditions Predisposing to Suicide: A Review, J. Nerv. Ment. Dis. 164:231-246, 1977.
15. Jacobs, D. Epidemiology of Suicide Attempts. Paper presented at symposium on suicide, Harvard Medical School-Cambridge Hospital, Boston, Feb. 1, 1985.
16. Paerregaard, G.: Suicide Among Attempted Suicides: A 10-Year Follow-up, Suicide 5:150-144, 1975.
17. Ettlinger, R.W.: Suicide in Group of Patients Who Previously Attempted Suicide, Acta Psychiatr. Scand. 40:363-378, 1964.
18. Shneidman, E.S.: Some Essentials of Suicide and Some Implications for Response, in Suicide, edited by Roy, A., Baltimore, Williams and Wilkins, 1986.
19. Tuckman, J. and Youngman, W.F.: Scale for Assessing Suicide Risk of Attempted Suicides, J. Clin. Psychol. 24:17-19, 1968.
20. Kreitman, N.: Parasuicide, New York, John Wiley & Sons, 1977.
21. Phillips, D.P. and Carstensen, L.L.: Clustering of Teenage Suicides After Television News Stories About Suicides, N. Engl. J. Med. 315:685-689, 1986.
22. Hawton, K.: Suicide in Adolescents, in Suicide, edited by Roy, A., Baltimore, Williams and Wilkins, 1986.
23. Temoche, A.; Pugh, T., and MacMahon, B.: Suicide Rates Among Current and Former Mental Institution Patients, J. Nerv. Ment. Dis. 138:124-130, 1964.
24. Greenberg, S.L.; Rosario, A., and Hornberger, R.H.: Suicide Threats: Study in Communication. Paper presented at annual meeting of American Association of Suicidology, Anchorage, May 3, 1984.
25. Kovacs, M.; Beck, A.T., and Weissman, M.A.: Communication of Suicidal Intent, Arch. Gen. Psychiat. 33:198-201, 1976.
26. Pokorny, A.D.: Prediction of Suicide in Psychiatric Patients: Report of Prospective Study, Arch. Gen. Psychiat. 40:249-257, 1983.
27. Lettieri, D.: Suicidal Death Prediction Scales, in Prediction of Suicide, edited by Beck, A., Resnick, H., and Lettieri, D., Bowie, Charles Press, 1974.
28. Beck, A.T.; Weissman, A.; Lester, D., et al: Measurement of Pessimism: The Hopelessness Scale, J. Consulting Clin. Psychology 42:861-865, 1974.
29. Motto, J.A.; Heilborn, D.C., and Juster, R.P.: Development of Clinical Insttument to Estimate Suicide Risk, Am. J. Psychiat. 142:680-685, 1985.
30. Pallis, D.J.; Gibbons, J.S., and Pierce, D.W.: Estimating Suicide Risk Among, Attempted Suicides: II, Efficiency of Predictive Scales After the Attempt, Br. J. Psychiat. 144:139-148, 1984.
31. Beck, A.T.; Steer, R.A.; Kovacs, M. et al: Hopelessness and Eventual Suicide: A 10-Year Prospective Study of Patients Hospitalized with Suicidal Ideation, Am. J. Psychiat. 142:559-563, 1985.
32. Murphy, G.E.: Physician's Role in Suicide Prevention, in Suicide, edited by Roy, A., Baltimore, Williams and Wilkins, 1986.
33. Havens, L.L.: Recognition of Suicidal Risks Through Psychologic Examination, N. Engl. J. Med. 276:210-215, 1967.
34. Schwartz, D.A.; Flinn, D.E., and Slawson, P.E.: Suicide in Psychiatric Hospital, Am. J. Psychiat. 132:150-153, 1975.
35. Caplan, G.: Principle of Preventive Psychiatry, New York, Basic Books, 1964.
36. Fox, R.: Recent Decline of Suicide in Britain: Role of Samaritan Suicide Prevention Movement, in Suicidology, edited by Shneidman, E.S., New York, Grune and Stratton, 1976.
37. Wold, C.I. and Litman, R.E.: Suicide After Contact with Suicide Prevention Center, Arch. Gen. Psychiat. 28:735-739, 1973.
38. Wilkins, J.A.: Follow-up Study of Those Who Called a Suicide Prevention Center, Am. J. Psychiat. 127:155-161, 1970.
39. Beher, H.A.: Suicide: A Legal Perspective,in Lifelines: Clinical Perspective on Suicide, edited by Bassuk, E.L.; Schoonover, S.C., and Gill, A.D., New York, Plenum Press, 1982.
40. Personal communication, Executive Secretary of the American Association of Suicidology.

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"Zero Tolerance"

We have all experienced the frustrations of dealing with non-medical agencies and personnel with access to control over our practices — whether the nurse-administrators of an HMO/PPO, low echelon personnel of the PRO, Medicare/Medicaid and third-party insurer clerical claims processors, a growing number of governmental regulatory agencies, non-medical entrepreneurs entering our marketplace, or the trial bar with their expert witness skills. All these act through the purse strings, and as such can confront us either forcefully or seductively; it's very easy to give in to someone who purports to guarantee us patients or avoid the trouble and expense of our own marketing and management.

This is a classic Catch-22 situation. Of course, we dare not modify our practices in ways not in our patients' best interests (for any number of good reasons, which include our training and ethics). But in these interactions, our proper medical choices are abridged by differences between our trained perceptions of correct actions and what these lay controllers determine as cost-effective action. These are not reasonable differences in medical judgment between educated physicians. These differences are uneducated in origin, arbitrary, and prone to be quickly made public — by patient notification of denial of payment or through a number of other routes. This also makes good story material to the press, playing for sales on painting us as an elite worthy of public jealousy. The stage is set for a long and loud adversarial relationship between our profession and the public at large.

Medical exiles from democratic countries with socialized health care (Canada, Britain) recognize this scenario for the demise of fee-for-service private practice. So long as we let medical issues become politicized without effectively interacting in the political process, so long as we let ourselves be regulated without becoming the regulators ourselves, and allow ourselves to be objects of public jealousy and press vendetta without effective public response, free enterprise in patient care in the public interest will be lost in arguments of political economy and expedient social justice. Senator Kennedy, for one, has accepted the argument that these foreign imports can offer superior access at lower cost, without paying attention to the inevitable tradeoffs. And there will be tradeoffs in any situation of third-party payment for expensive, technology-intensive, expertise-intensive care. Call it *rationing*, and make sure your patients understand that. As the discussions toward resolving the admitted problems in American health care evolve, physicians should be aware of the implications of such directions, and be ready and poised to fight.

Any Canadian or British physician can tell you that the real issue in developing these systems is unthinking non-medical control of access to medical resources. Political victories lie in keeping costs down by restricting access — particularly to new technologies and expensive in-patient care — in ways not visible to the lay public, and an antagonistic press is the regulators' best ally. Errors in public policy can always be salvaged by another round of doctor-bashing in the legislature and press. We have all begun to see this with DRG-mania and with public acceptance of gatekeeper HMOs, and more is promised. The question is whether we are willing to see public policy guarantee unlimited public access to lowest-common-denominator primary care (as in Canada or Britain) at the cost of:

- making current technology unavailable or highly restricted (tPA, non-ionic contrast agents for CNS imaging, linear accelerators, coronary artery bypass surgery, lithotripsy, CT and MR imaging);
- seeing public policies which specifically limit classes of patients eligible for certain treatments (dialysis, chemotherapy);
- or of restricted licensure by which payment depends on your obeying government dictates of specialty or location. (Do Constitutional guarantees preclude discrimination by profession?);
- or global rationalization of hospital resources with arbitrary relocations and closures, and exclusion of physicians and others from for-profit investment in facilities.

A brave new world? All of these already exist in Britain or Canada; is the American psyche much different? Even the British — 30 years later — have realized the errors in the planning and execution of the National Health System and have moved to reinstate for-profit hospitals and private insurance; but at the same time, Canada in 1986 outlawed all vestiges of practice outside the national Medicare system.

We have expert knowledge with vested interests in quality medical care. We must be our own expert

witnesses in support of ourselves and our patients. If we cannot mold ourselves into an effective and united opposition that formulates constructive alternatives and places our concerns fairly and forcefully before the media and public, making it known that opposition is in the mutual best interest of all parties, we can hardly expect our patients — the electorate — to support us.

Why join? Why be organized? Those of us whose professions have been sold out before, in other countries, recognize the syndrome and can make the diagnosis. We must be unified, vocal, financially strong, able to support our allies and educate our public if we are to maintain private practice as we know it in the face of strong public policy. Our attitude toward any further such encroachment must be clear — "zero tolerance."

Barry S. Tepperman, M.D.

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Advancements Change Nature of Medicine

With the great advancement of medical technology in the last 100 years, the art of medical practice has become subordinate to the mechanical science. Gone are the days of house calls, patient reassurance and public admiration. Instead, modern physicians are faced with the crises of malpractice, public mistrust, and patient depersonalization. The time has come for physicians to scrutinize the quality of their relationships with their patients. Development of the art of medicine must become a priority in the physicians continuing medical education. As professionals, we must succeed in demonstrating genuine concern for patients as individuals instead of caring only about their disease.

Survey data show that many sick persons don't seek treatment from doctors; conversely, many people who do visit doctors are without serious medical disease. Therefore, it follows that factors other than disease and symptoms must be important in a patient's decision to consult a physician.[1]

Studies of ambulatory medical practice have shown that 68-92% of all patients do not have serious physical disorders. Ten to 60% of patients with each of the five most common presenting medical complaints have been discovered to have no structural disease that is responsible for their symptoms. Inherent in these statistics is the difference between sickness (the biological malady) and illness (the person's experience of that sickness and the behavior that results.)[1]

Physicians (and medical students) often become preoccupied with the sickness and forget to consider the importance of the illness. The psychosocial aspects of illness are frequently undermined when really they are of primary importance in affecting the outcome of a patient's disease. As a doctor it is paramount to uncover how in the patient's view health and illness impact on family, housing, friends, religion, and hobbies. Physicians should also realize that culture and ethnicity greatly affect how a patient will view illness and treatment. Patient compliance, or lack of it, it also related to cultural views of disease and therapy. Thus, it behooves the physician to inquire about how the patient perceives the illness.

Patients sometimes visit doctors' offices for hidden reasons. Often they request medical consultation because of distressing events, social isolation, psychiatric disorders or a desire for health information. Other patients who are isolated and lack adequate interpersonal relationships turn to physicians for advice, consolation, and simple conversation. The doctor-patient relationship is ideal for these patients because it can be entered into with relative ease.[1] Being examined by a physician if even for a few minutes, embodies these patients with a sense of power in that they are the sole object of their doctor's attention and concentration.

In a recent consumer oriented study done in Texas, patients ranked by order of preference their greatest needs in choosing a physician. They were as follows: 1) a physician who listens, 2) high quality care with up-to-date techniques, 3) seeing the same physician every time, 4) direct telephone access to the physician for follow-up advice, 5) friendly office staff, and 6) short waiting time.[5]

It is not surprising that a physician who listens is the top preference of patients. Probably the type of listening that these patients seek is the "therapeutic kind." Therapeutic listening is a deep awareness of another's feelings; an almost spiritual sense of con-

nection and closeness between physician and patient. For a few physicians consistent therapeutic listening comes naturally, others must continually work at developing this essential art.

The continuity of the physician-patient relationship is also a high preference of patients. Patients, once having developed a therapeutic alliance with their doctor, don't like having it interrupted except under extenuating circumstances. For patients, having to be seen by a different doctor who is not familiar with them or their medical history is very uncomfortable.

Patients also value having direct access to their physician when further advice is needed. Obviously physicians are not always free to come to the phone during the course of their day. However, making the effort to return patients' phone calls promptly is a courtesy and shows commitment on behalf of the doctor.

Having to deal with rude office staff and finally being seen by the doctor hours after a scheduled appointment are both universal complaints among patients. Medical staff often over-book the schedule to compensate for non-shows. They forget that valuable lost time spent in the waiting room causes resentment among patients. Office staff are also guilty of getting so involved in paperwork that they overlook manners and common courtesy. Receptionists and secretaries are often the first people patients meet. If the initial contact with the office staff is adversarial, the patient may enter the examining room with a negative attitude.

In conclusion, patients who express dissatisfaction with their medical care may be unhappy because their real motives in seeking care have not been recognized and dealt with. The time has come for us to focus on the commonplace world where two people meet and communicate — one as doctor and one as patient. Inherent in these interactions are the trivialities and nuisances of everyday life. But as physicians, we earn the privilege of witnessing the mysteries of birth, life, growth, illness, healing, and finally death. It is through maximizing the therapeutic alliance with patients that doctors receive the utmost rewards and fulfillment from the rigorous demands of their professions.

References

1. Barsky, A.J. Hidden reasons some patients visit doctors. Ann Intern Med. 1981: 94 (4 pt 1): 492-8.
2. Burnett, A.C., Thompson, D.G. Adding the development of communications skills in medical students. Medical Education 1986:20(5): 424-431.
3. Carmel. S., Bernstein, J. Identifying with the patient: an intensive programme for medical students. Medical Education. 1986; 20(5): 432-436.
4. Kraushar, Marvin F, Conspectus: Malpractice and the Physician-Patient Relationship. Comprehensive Therapy. 1987; 13(6): 3-4.
5. Page, L., MD's Secrets for success in million-dollar clinics. American Medical News. 1988: 13-15.
6. Suchman, A L., Mathews, D.A., What makes the Patient-Doctor Relationship Therapeutic Exploring the Connexial Dimension of Medical Care. Annals of Internal Medicine. 1988: 108(1): 125-130.

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Titles should be short, specific, clear and amenable to indexing. Titles should not exceed 80 characters, including punctuation.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should be included.

Abstract: All scientific manuscripts must include an abstract of not more than 150 words. The abstract is a factual (not descriptive) summary of the work which replaces the summary and precedes the articles.

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Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a short title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

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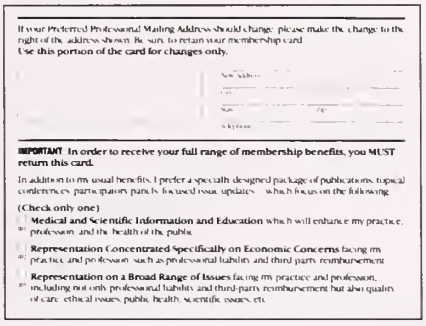

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Farewell to William B. Deal, M.D.

William "Will" B. Deal, M.D., has accepted the appointment as President of the Maine Medical Center in Portland and will assume his duties on or about October 1. Will and his wife, Elizabeth, have been residents of Gainesville since 1963 when he began training in the Department of Medicine. Their two daughters, Kimberly and Kathleen, grew up in Gainesville. The University of Florida Health Science Center and the greater community of Gainesville won't be the same without the Deal family. Dr. Deal, a native of North Carolina, earned his M.D. degree from the University of North Carolina in 1963 before serving an internship in the Department of Medicine at the University of Florida Shands Hospital. After serving as medical officer in the United States Navy for two years, he returned to the University of Florida where he completed residency training in medicine and a fellowship in infectious disease, serving as Chief Resident and Instructor in the Department of Medicine in his final year of training.

Dr. Deal remained on the faculty in the Department of Medicine and assumed the duties as Associate Dean in the College of Medicine in 1973 and became Acting Dean in 1977. In 1978, after a national search, Dr. Deal was appointed Dean of the College of Medicine and Vice President for Health Affairs, a position which he held until 1980 when he left Florida to become Assistant to the Senior Vice President for the American Medical Association. After four months, Dr. Deal returned as Dean of the College of Medicine and Associate Vice President for Clinical Affairs, the position he has continued to hold since that time.

Under Dr. Deal's leadership for the past 15 years, the University of Florida College of Medicine and the Health Science Center have continued to develop and prosper. The College of Medicine is a very young school by national standards, having graduated its 29th class in June 1988. In 1983 it was awarded ten year accreditation status, the highest term of accreditation that can be attained by a medical college. Out of the 127 medical schools in the United States, fewer than 25 have been accredited for the full ten years. The faculty has almost doubled under Dr. Deal's administration, expanding from approximately 250 to nearly 500 members this year. Sponsored research awards from federal, state and other sources total more than $160 million over the past ten years, and the college's budget expenditures have more than tripled since Dr. Deal became Dean — increasing from $32 million in 1977 to more than $105 million in the last fiscal year.

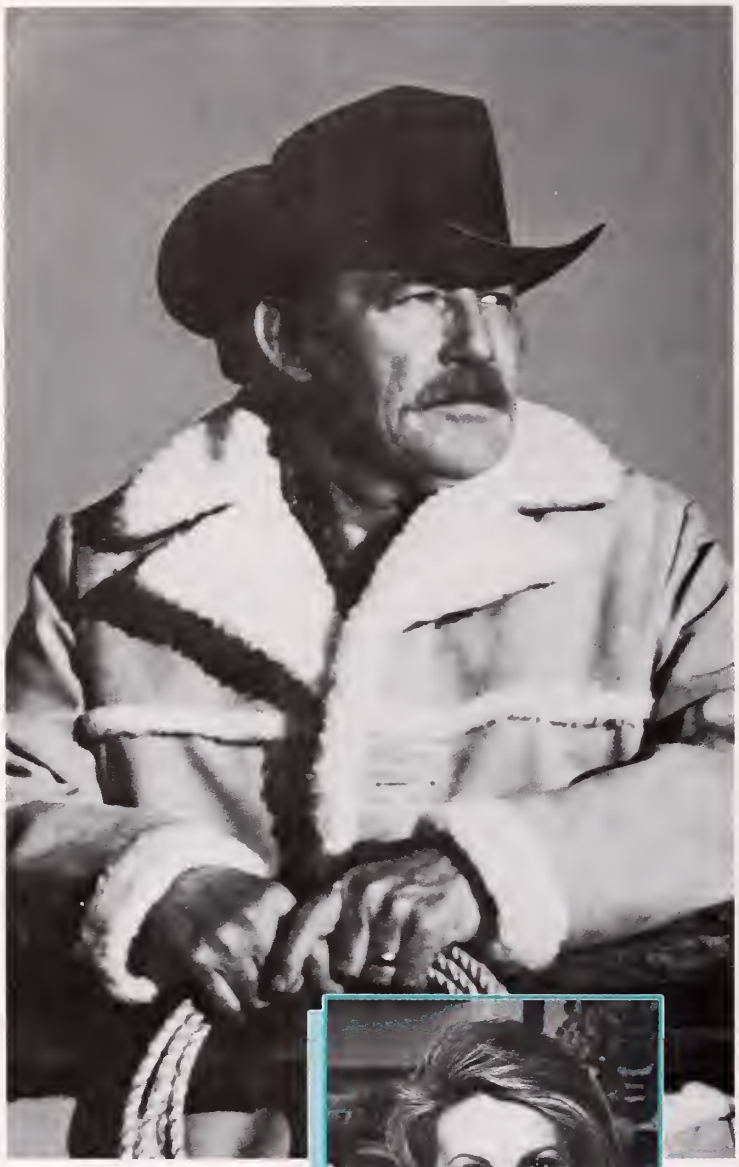
It takes skill and diplomacy to direct a college as large and diverse as the University of Florida College of Medicine. No one has managed to do better than William B. Deal, M.D. His warm handshake and genuinely friendly manner, coupled with his traits of leadership, including objectivity and ability to listen to others, have earned him great respect among his colleagues, alumni, students, faculty, and friends.

Private giving, which is extremely important to support the educational programs of the College of Medicine, has increased significantly during Dr. Deal's tenure. He has been instrumental in securing a $8.47 million dollar gift from Nautilus inventor Arthur A. Jones, the largest single gift ever made to a public university in Florida. With 13 eminent scholar chairs to his credit, the College of Medicine has, by a wide margin, the largest number of $1 million endowed chairs at the University of Florida and the only $5 million endowed "super chair."

Will Deal is sometimes referred to as the "Dean's Dean," as Chairman-Elect of the Council of Deans of the Association of American Medical Colleges (AAMC) and a member of the AAMC Executive Council and the Council of Deans Administrative Board. He is also past chairman of the Governing Council for the American Medical Association Section on Medical Schools and a member of many special task forces and committees of both the AAMC and the American Medical Association.

All of us at the University of Florida Health Science Center and throughout the state will miss Will Deal's presence, but congratulate him on his new position and wish him and his family all the best in the future. Florida's loss is Maine's gain. Farewell William B. Deal, M.D.! Your strong influence has benefited the University of Florida College of Medicine for years to come. You have left us a wonderful legacy on which to continue to build.

J. Lee Dockery, M.D.
Executive Associate Dean
University of Florida College of Medicine



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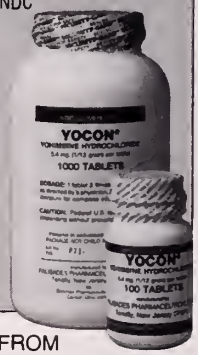

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

Better Health For Better Living

Another Auxiliary year is over and I congratulate each member and thank them for a job well done. As we move forward to a new year and its programs and projects, let's take a brief look at what was accomplished in 1987-88.

As we are all aware, the proposed constitutional amendment was top priority. The Auxiliary was asked to spearhead the petition drive and members were at the forefront soliciting signatures in neighborhoods, hospitals, clinics, and offices as well as outside the polling places on Super Tuesday. We are very proud of the part we played in this project which, with the FMA, was carried through to successful conclusion.

At the request of FMA President James G. White, M.D., one of our projects this year was to begin the promotion of an educational program to combat teen pregnancy and sexually transmitted diseases. Preliminary steps we taken and a pilot program established when a delegation from the Auxiliary met with representatives of the Commissioner of Education. I am happy to report that there was expression of significant interest by the Commissioner's staff, and we expect to work together on development of plans to implement the program.

We are especially proud of our family support groups which were started this year as a component of the Florida Physicians Recovery Network. There are now more than 200 family members of impaired physicians participating in the program. As spouses of physicians, we are particularly enthusiastic since this is one of the few times that our efforts so directly benefit "our own".

Once again Auxilians throughout the state demonstrated their support of AMA-ERF with a total contribution of $114,528.89. While the sharing card and sales of greeting cards were the most frequent fund raisers, counties also held special events such as covered dish dinners, fashion shows, and bazaars to earn additional contributions.

Health services in the local communities accounted for a large part of each county's projects. With Florida's extensive proportion of elderly citizens, programs for the aging were numerous and varied. Auxilians participated in educational and Hospice programs, visiting, meal programs, transportation services, day care, telephone reassurance, and the medi-file project. At the other end of the age spectrum, counties supported programs addressing adolescent pregnancy, teen sexuality, child abuse, teen drug abuse, GEMS, and teen suicide. There were blood drives, scholarships, volunteers for mental health programs, projects stressing home, bicycle, and automobile safety, a particularly popular Women's Enrichment Clinic as well as auxiliary sponsorship of Health Careers clubs, days or fairs. Local auxilians also participated in screening fellow Floridians for hearing and vision problems, cancer, hypertension, scoliosis, and immunization.

I have shared only a few of the projects and they represent much, much more in the programs undertaken and especially in the time and hard work put forth throughout the year.

To the officers, Board of Governors, and members of the Florida Medical Association go my heartfelt thanks for their assistance to me during my term of office, and for their unfailing and continued support of our programs and projects.

Mrs. Rex (Betty) Orr, President
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BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

Gastroenterologic Endoscopy

Edited by Michael V. Sivak Jr., 1168 pp., illustrated. Philadelphia, W.B. Saunders, 1987. $150.

If, like the hero of *Back to the Future*, I had been transported back to 1983 or even 1985 to read this book, I would have found it the most impressively focused textbook of gastrointestinal endoscopy that I had encountered. The four or five atlases that have appeared over the past few years to improve the erudition of students of gastrointestinal disease have been more geographic than geologic, containing pictures that are useful but that do not have the cognitive detail that Sivak's contributors provide. I have considered Blackstone's book *(Endoscopic Interpretation.* New York, Raven Press, 1984) the best for an overall approach, and I am not sure whether it has been superseded by this new compendium. For comparison, Blackstone — hitherto the standard, I think — is rather like Sheila Sherlock's book on the liver *(Diseases of the Liver and Biliary System*, 7th ed. St. Louis, C.V. Mosby, 1985). When you finish with it, you have a number of contributors from all over the United States and Europe, is far more catholic, delving into problems more deeply and presenting sections on basic science and physics, along with advice on how to organize an endoscopic laboratory. It touches on so many topics that it will have to be the vade mecum for endoscopists.

Endoscopists, for whom the book is intended, will find no long disquisitions on medical therapy here, or on etiology — matters covered in other books. Instead, all 1168 of these pages are devoted to peering at the gut through the endoscope and evaluating and treating it that way. There are few wasted pages.

The main problem one encounters in using this book, for which I sympathize with its editor, is that the bulk of the manuscripts were apparently written in 1983 or (stretching it) in 1984. Why it took another three or four years for the work to come to fruition is known only to the editor and the publisher (who, incidentally, seems to favor a somewhat old-fashioned typeface). Maybe they had to wait for dilatory contributors. Clearly, the editor feels bad about this; many of the chapters have a plaintive apologia referring to the "rapid growth" of the field and supplying references (not usually discussed in the text) from 1985 or 1986. For example, the threat of the acquired immunodeficiency syndrome (AIDS) to endoscopists and the precautions that must be observed in patients with gastrointestinal bleeding — among others — are not really given the amount of hortatory consideration that a book published in 1987 should have devoted to that sad topic. I am always amazed that endoscopists inspecting the mucosa of patients with gastrointestinal bleeding assume that blood that comes out of the mouth is less likely to contain the AIDS virus than that contained within the vessels. In that regard, video-endoscopy, which enables the endoscopist to keep his or her eyes and oral mucosa at a greater distance from vomited blood and saliva, might have merited greater attention than it received. Moreover, video-endoscopy lets me see exactly what the endoscopist has seen, without all the trouble that he or she has gone through, and with a fast-forward feature.

Cavils about date aside, this book is a remarkable achievement, teaching me (who learned endoscopy in 1947, when we scrubbed but did not use gloves) a great deal about the techniques of modern endoscopy. Blackstone may be pleasanter reading for the dilettante who wants to acquire some knowledge of endoscopy, but Sivak will prove essential to all who pretend to make endoscopy a profession. For penance, the publisher owes the editor a quick turnaround time for a second edition, which — it may be predicted — will be a leader. Even the present edition will be essential in all gastrointestinal units, as required reading for those attempting to establish such units and to make the more prehensile gastroenterologists into endoscopists.

Howard M. Spiro, M.D.
Yale University School of Medicine

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Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

OCTOBER

Advances in Musculoskeletal Magnetic Resonance Oct. 1, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 972-3351.

Magnetic Resonance Imaging for the Clinician, Oct. 1, Tampa General Hospital, Tampa. Contact: Carlos Martinez, M.D. (813) 251-7770.

Basic Trauma Life Support Provider Course, Oct. 1-2, University South Florida, Tampa. Contact: James Hilman, M.D. (813) 251-6911.

Heart Disease, Emotions & Stress, Oct. 5, Tampa. Contact: Stephen Glasser, M.D. (813) 974-2880.

17th Annual Cardiopulmonary Seminar, Oct. 6-9, Sheraton Sand Key, Clearwater Beach. Contact: James Eutzler, D.O. (813) 586-7103.

Intervention Training for the Helping Professions', Oct. 7, Holiday Inn, Pensacola Beach. Contact: James Eutzler, D.O. (813) 586-7103.

Risk Management Seminar, Oct. 8, Pasco County Medical Society, Pasco County. Contact: Pasco County Medical Society (813) 848-1644.

Risk Management Seminar, Oct. 8, Good Samaritan Hospital, West Palm Beach. Contact: Laura Lyons (407) 650-6236.

Legal & Ethical Issues In Occupational Health, Oct. 14-15, Howard Johnson Hotel, Tampa. Contact: Nicholas Alexious, M.D. (813) 974-3294.

Magnetic Resonance Imaging for the Clinician, Oct. 15, Tampa General Hospital, Tampa. Contact: Carlos Martinez, M.D. (813) 251-7770.

ACLS Provider Course, Oct. 15-16, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

Magnetic Resonance Imaging, Oct. 17-21, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Risk Management Seminar, Oct. 18, Orange County Medical Society, Orange County. Contact: Orange County Medical Society (305) 841-6267.

Changing Concepts in the Management of Hypertension, Oct. 18, Grand Bay Hotel, Coconut Grove. Contact: Murray Epstein, M.D. (305) 547-6716.

Calcium Antagonists — 1988, Oct. 18, Grand Bay Hotel, Coconut Grove. Contact: CME Department (305) 547-6716.

Pediatric Care Network, Oct. 19, Miami. Contact: Dr. Nieves/Dr. Wurm (305) 549-7600.

VI Annual Advanced Neuroradiology Seminar, Oct. 21-23, Hyatt Regency Hotel, Orlando. Contact: Agnes Bridges (813) 251-7778.

Risk Management Seminar, Oct. 22, Volusia County Medical Society, Volusia County. Contact Volusia County Medical Society (904) 255-3321.

Cardiac Pacing and Electrophysiology — 1988, Oct. 22-23, Innisbrook Resort, Tarpon Springs. Contact: Peter Alagona Jr., M.D. (813) 870-4155.

Tutorial Courses of Instruction in Acute Cardiac Care, Oct. 24-29, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 594-6411.

Moral Medicine, Oct. 26-30, Airport Marriott, Tampa. Contact: William Reed, M.D. (813) 923-3688.

29th Workshop in Electrocardiography, Oct. 26-31, Sheraton Sand Key, Clearwater Beach. Contact: Henry J.L. Marriott, M.D. (813) 894-0790.

Minority Health Symposium III, Oct. 27-28, Marriott Hotel, Biscayne Bay. Contact: Ellen Opeheimer (305) 573-0220.

Risk Management Seminar, Oct. 29, Holiday Inn, Altamonte Springs. Contact: M.P. Demos, M.D. (800) 431-3878.

NOVEMBER

Traumatic Spinal Cord & Head Injury, Nov. 3-4, Holiday Inn, Pensacola Beach. Contact: Rose Marie Harvey (904) 474-5358.

Magnetic Resonance Imaging, Nov. 7-11, University Diagnostic Institute, Tampa. Contact: Martin Sillbiger, M.D. (813) 974-2538.

Cardiac Update, Nov. 10, FSU Conference Center, Tallahassee. Contact: Mollie Hill (904) 877-9018.

Florida Society of Clinical Hypnosis, Nov. 10-13, Miami. Contact: Linda K. Tower. (305) 547-2000.

Risk Management Seminar, Nov. 12, Airport Hilton, Tampa. Contact: M.P. Demos, M.D. (800) 431-3878.

Pediatric Care Network, Nov. 16, Miami. Contact: Dr. Nieves/Dr. Wurm (305) 549-7600.

AIDS Lecture Series, Nov. 17, Miami and Ft. Lauderdale. Contact: Richard Burton (305) 547-6867.

Directions in Pediatric Hematology/Oncology Care, Nov. 17-19, Harbour Island Hotel, Tampa. Contact: Cindi Butson (904) 375-6848.

ACLS Provider Course Provider Course, Nov. 26-27, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

DECEMBER

Risk Management Seminar, Dec. 3, Holiday Inn Calder, Miami. Contact: M.P. Demos, M.D. (800) 431-3878.

Tutorial Courses of Instruction In Acute Cardiac Care, Dec. 5-10, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Gastrointestinal Endoscopy, Dec. 7-10, Buena Vista Palace, Lake Buena Vista. Contact: Worth Boyce Jr., M.D. (813) 974-2034.

Clinical Allergy & Immunology for the Practicing Physician, Dec. 8-10, Lake Buena Vista. Contact: Richard Lockey, M.D. (813) 972-7631.

First Annual Ocala Cardiovascular Day, Dec. 10, Ocala Hilton, Ocala. Contact: Rhonda Grubbs (904) 351-7206.

Basic Trauma Life Support, Dec. 10-11, Univ. South Florida, Tampa. Contact: James Hillman, M.D. (813) 251-6911.

Magnetic Resonance Imaging, Dec. 12-16, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Pediatric Care Network, Dec. 21, Miami. Contact: Dr. Nieves/Dr. Wurm (305) 549-7600.

JANUARY

12th Annual Oral Pathology Review, Jan. 7-11, Hyatt Regency, Miami. Contact: CME Department (305) 547-6716.

21st Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 10 & 12, Hotel Intercontinental, Miami. Contact: Victor A. Politano, M.D. (305) 687-1367.

34th Annual Cardiovascular Seminar, Jan. 13-14, Manatee Civic Center, Bradenton. Contact: Melissa S. Crater (813) 867-5000.

Magnetic Resonance Imaging, Jan. 16-20, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Topics in Pediatrics: 1989, Jan. 19-21, Lake Buena Vista Place, Orlando. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Tutorial Courses of Instruction In Acute Cardiac Care, Jan. 23-28, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Critical Care Medicine, Jan. 31-Feb. 1, Sheraton Royal Biscayne, Key Biscayne. Contact: Dept. of CME (305) 547-6716.

FEBRUARY

A.S.P.E.N.'s 13th Clinical Congress, Fontainbleau Hilton, Miami Beach. Contact: Karen MacFirland (305) 587-6315.

Magnetic Resonance Imaging, Feb. 6-10, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Cardiopulmonary Rehabilitation, Feb. 13-16, Orlando. Contact: Michael Pollock, Ph.D. (904) 392-9575.

Florida Thoracic Society's 11th Annual Pulmonary Wintercourse, Feb. 16-19, Contemporary Resort, Lake Buena Vista. Contact: Richard Doggett (904) 743-2933.

The Journal of the Florida Medical Association, Inc.

CLASSIFIED ADVERTISING FORM

Please print or type all information requested and return this form to Kathy S. Lundy, Managing Editor, *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203. **Deadlines for publication are the first of the month preceeding the month of publication.** *For example:* An ad to be run in October should be received by *The Journal* by September 1. **Classified advertising costs:** $10.00 for 25 words or less; then 25¢ for each word thereafter.

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EMERGENCY PHYSICIANS: Excellent opportunities available for full-time and part-time physicians on the East Coast, West Coast and Panhandle portions of the state. Hospital volumes vary. Positions offer excellent compensation and malpractice insurance. Respond with C.V. to Anita Stirt EMSA, 100 N.W. 70th Avenue, Plantation, FL 33317, or call 1-800-443-3672.

EMERGENCY MEDICAL GROUP, a progressive, physician-owned organization is seeking full and part-time Board certified/eligible and Family Practice physicians for openings in Southeast Florida. Competitive salary, paid malpractice insurance, benefits and attractive scheduling. Send CV to Emergency Medical Group, 1400 NW 12th Ave., Miami, FL 33136.

FAMILY PRACTICE — Great opportunity to join a busy solo practitioner in Lake Worth (West Palm Beach). Board certification/eligibility required. Contact Art Altbuch, M.D., 3918 Via Poinciana, Suite 5, Lake Worth, FL 33467, 305-433-1700.

EMERGENCY MEDICINE — Immediate opportunity exists for an ER physician in the beautiful Blueridge foothills of western Virginia. Picturesque community with a strong economy boasts of good schools, and offers many recreational and cultural activities. Independent contract offers competitive compensation including malpractice insurance and tail coverage participation. 14K visits/year. Supported by progressive 150-bed hospital. Contact Don Gustavson, TYLER & CO., 9040 Roswell Rd., Atlanta, GA 30350. Call (404) 641-6411.

FLORIDA — EXPANDING FAMILY PRACTICE seeking BC/BE family practitioners to join thriving two-physician group. Excellent opportunity for potential partnership. Involved in both prepaid and fee-for-service practice. Competitive salary incentive program and full benefit package. Highly desirable area, practice environment in a dynamic South Florida community. Please send CV to: Mark A. Vacker, M.D., 4801 S. University Drive, Davie, FL 33328.

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GENERAL THORACIC & VASCULAR SURGEON as associate or share office space in Orlando area. Florida license and Thoracic Boards. C.V., photo and personal information with references first letter please. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1366, Jacksonville, FL 32203.

FAMILY PRACTICE Marshfield Clinic is seeking BE/BC Family Practitioners to join its expanding department in Marshfield. The department is currently staffed by five Family Practitioners with plans to ad three additional members. With the exception of obstetrics, which is done by staff obstetricians, the practice offers a full range of inpatient and outpatient services. Full specialty consultation is readily available inhouse. Our community of 20,000 offers strong economic stability combined with exceptional recreational, cultural, and educational opportunities. Salary and fringe benefit package outstanding. Send CV and references to David L. Draves, Department of Administration, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect (715) 387-5376.

IMMEDIATE NEED FOR A BC/BE Neurosurgeon to join successful, solo practitioner in Florida. Supported by 750 bed medical center, opportunity offers a ready-made practice in this beautiful, coastal community of 200K. Contact Jim Davis, Tyler & Co., 9040 Roswell Rd., Atlanta, Ga., 30350. Call (404) 641-6411.

PRIMARY CARE/FAMILY PRACTICE PHYSICIANS (2) and OB-GYN Physicians (2) for new multi-service health facility in Bradenton. Positions now available with rapidly expanding Primary Care Program in County Public Health Unit. Must be licensed in the State of Florida and BC/BE. Excellent salary and fringes, malpractice insurance paid. Contact: Personnel, Manatee County Public Health Unit, 202 Sixth Avenue East, Bradenton, Florida 34208.

FAMILY Practice (BC/BE), or Neurologist, or Pulmonary Specialist, Central Florida, outdoor recreation and resort area, well-equipped, modern hospital, positive demographics, congenial medical staff, small-town atmosphere, yet near major urban area. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1464, Jacksonville, FL 32203.

OCCUPATIONAL MEDICINE: Physician relocation specialist. Nineteen years experience nationwide. Send Curriculum Vitae in confidence. Robbins Med-Tech, P.O. Box 51509, Jacksonville, FL 32240. (904) 223-0440.

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U.S. LICENSED PHYSICIANS wanted for Cruise Ships ACLS preferred, 2-6 month term. Send resumes to Port of Miami Medical Clinic, 1001 N. America Way, Miami, Florida 33132.

GENERAL INTERNIST: BC/BE, Immediate Opening, excellent opportunity to join large solo practice in a beautiful Gulf Coast area. Salary guaranteed with incentives for full partnership. Please forward resume to: P.O. Box 6657, Ft. Myers, FL 33911.

PSYCHIATRISTS — FLORIDA: Immediate openings for Psychiatrists at Northeast Florida State Hospital located 30 minutes from Jacksonville, 50 minutes from Gainesville. Comprehensive benefit package including malpractice insurance. Salary negotiable. Board eligible or certified preferred. Hospital has affiliation with University of Florida, Department of Psychiatry. Clinical faculty appointment available for qualified applicants. Supervisory position available for qualified applicant. Contact: E. Zebooker, D.O., (904) 259-6211, ext. 111, NEFSH, Macclenny, FL 32063 EOE/AA

PHYSICIAN WANTED — Immediate opening full or part time — HMO Office Fort Lauderdale, Florida. Call Debbie (305) 981-4444, Associated Medical Centers of Broward.

GENERAL PRACTITIONER for out-patient services only. No weekends, low stress. Gulf coast area. Reply: Florida Medical Association, Inc., P. O. Box 2411, C-1490, Jacksonville, FL 32203.

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NON-INVASIVE BC/BE Cardiologist — Excellent clinician with expertise in Echo/Doppler and stress testing. Beautiful gulf coast area. Send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1490, Jacksonville, FL 32203.

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FULLY EQUIPPED MEDICAL clinic in Hobe Sound, FL has office space available for full time internal medicine, family practice or specialists in other fields. Excellent opportunity also for satellite office. Please send CV to: Florida Medical Association, Inc., P. O. Box 2411, C-1491, Jacksonville, FL 32203.

ALL SPECIALTIES REQUIRED: Physician relocation specialist. Sunbelt locations with groups or hospital based. Send Curriculum Vitae in confidence. Robbins Med-Tech, P.O. Box 51509, Jacksonville, FL 32240. (904) 223-0440.

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PANHANDLE — OB/GYN, FP, ENT, Ped, O/S, An. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

S.E. FLORIDA — OCC. MED. (must have FAA certification), FP (female), O/S (hand). Send CV or telephone. Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, (813) 968-3878.

INTERNIST/RHEUMATOLOGIST seeks practitioner in any specialty to share large equipped office in Miami area. Available immediately call (305) 856-6161.

FP, GP, IM needed for salaried positions in Alabama. Also, guarantees if you prefer to establish your own practice. Compensation packages (including malpractice) more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

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CENTRAL AND COASTAL FLORIDA/NATIONWIDE opportunities available now for BC/BE physicians. Complete confidentiality, send CV or telephone: Frank B. Lane, M.D., Medical Director, MCA, 5121 Ehrlich Road, Suite 107A, Tampa, FL 33624, (813) 968-3878.

PHYSICIAN: S. Florida HMO seeking a qualified, competent, confident and CARING hands-on Family Medicine or Internist Physician. Board Certified/Eligible preferred. Resume to: Jove Med-Care, 5200 NW 33 Ave., Ft. Lauderdale, FL 33309, Attn: S. Steinberg.

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University of Florida

The Student Health Service at the University of Florida currently has a physician position available. Candidates must possess a medical degree from a recognized medical college, be licensed to practice medicine in Florida, and either have completed one year of internship in addition to two years of residency in a recognized specialty or have four years of general practice experience. Board certification preferred in Family Practice, Internal Medicine, or Pediatrics. The candidate must also possess the ability to relate and work with a college age population. Anticipated starting salary is $52,685 and competitive depending on qualifications and experience. Excellent fringe benefits. Malpractice Insurance coverage provided.

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ORLANDO AREA (around lakes) — FP, IM, O/S, Non-Inv Card, Ped, Neur, Pulmonary. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

RADIOLOGIST NEEDED to join expanding group in central Florida Lake Country. Send CV to Raymond E. Lovelace, M.D., P.O. Box 3477, Sebring, FL 33870. (813) 385-4348.

OB/GYN or PERINATAL: 500-bed teaching hospital with 16-bed level III Perinatology Center needs clinician/teacher. Metro city of 185K in Piedmont area of NC. 5 colleges, good schools, low cost living, and excellent parks. Hospital-based with competitive pkg., benefits + malpractice. Contact Sandy Cundiff, TYLER & CO., 9040 Roswell Rd., Atlanta, GA. 30350. Call (404) 641-6411.

INTERNIST TO BUY OR PRACTICE with an active and busy internist of 30 years in Daytona Beach area. Arrangements very flexible. Call (904) 252-6335, evenings (904) 677-7097.

GENERAL INTERNIST FOR busy group practice. Tampa Bay Area. Salary guarantee with incentives and full benefits. Call (813) 654-2273.

TAMPA BAY AREA — Neurology, O/S, EM, IM, Occ. Med. Send CV to M.C.A., P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

N.E., FLORIDA — FP, O/S Non-Inv Card, ENT, AN, Rhu, OB/GYN. Send CV to Frank Lane, M.D., MCA, P.O. Box 272509, Tampa, Florida 33688 or call (813) 968-3878.

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WOULD LIKE TO SHARE or sublet new office 1685ft.^{2} located in Wellington, W.P.B., adjoining the Hospital. For more information contact: (407) 832-7118.

BOARD RECERTIFIED FAMILY PHYSICIAN leaving busy practice in Miami to move to North Tampa, Palm Harbor area looking for part time position with flexible hours. Send to: Florida Medical Association, Inc., P.O. Box 2411, C-1478, Jacksonville, FL 32203.

BOARD ELIGIBLE PATHOLOGIST, with six years experience in family practice, seeks opportunity to work in hospital, private group in pathology or family practice, walk-in clinic, public health. Reply to: Florida Medical Association, Inc., P.O. Box 2411, C-1479, Jacksonville, FL 32203.

PATHOLOGIST and PSYCHIATRIST. Husband and wife. Pathologist has Florida Medical license; Psychiatrist in application stage. Both board certified and experienced. Graduates of American Medical Schools. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1482, Jacksonville, FL 32203.

NON-INVASIVE CARDIOLOGIST desires position in SW Florida. Association with cardiology group preferred. University appointment: Associate Professor, BC IM and Cardiology. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1484, Jacksonville, FL 32203.

RETIRED BOARD CERTIFIED orthopedic surgeon seeks part time employment in Miami, FL area reviewing medical cases, hospital charts, quality assurance and peer review problems for hospital, state agency, insurance company or law firm. Reply: Florida Medical Association, Inc., P.O. Box 2411, C-1487, Jacksonville, FL 32203.

PRIMARY CARE PHYSICIAN currently practicing in Florida seeks opportunity in Miami and surrounding Southeast coast. Interested in office practice or out patient clinic only. Please write Florida Medical Association, Inc. P.O. Box 2411, C-1488, Jacksonville, FL 32203.

FP DESIRES TO purchase existing practice or join partnership with option to become part owner, in Fort Lauderdale area. Information held confidential. P.O. Box 6002, Tuscaloosa, AL 35405.

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FAMILY PRACTICE FOR SALE — Retiring — 35 years practice Fort Lauderdale, Florida. Fully equipped office, close to hospitals, six figure gross. Reply: Family Practice, 4306 NE 23 Ave. Ft. Lauderdale, FL 33308.

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Feature Editor — **Dale C. Havre, M.D.**

The Manic - Electronic Madness

I have observed another sign of illness in our society; perhaps some of you will disagree with my clinical acumen. Let me describe the sign and you can draw your own conclusions.

I have been spending time in the woods of northeastern Ohio very close to Pennsylvania. When I still had pulp in my lumbar discs, I walked spiritedly among the trees; however, I now cruise the trails on a mountain bike.

There is something very soothing about the forests. The terrain, although hilly and sometimes even mountainous, is seldom threatening. The layers of rock have been thrown into pleasing undulations by glaciers that visited long ago from Canada. Under foot, the soil is soft and thick and rich, dark brown and smells sweet, musty. Sturdy saplings grow contentedly at the feet of their parents, not discouraged by their prostrate, crumbling ancestors.

If you listen carefully, you can hear the hopping of a rabbit. Rapid scratching sounds are a good sign that a fat brown squirrel has scurried up a tree just ahead of you. Off in the distance you can hear water rushing over rocks. There probably is a waterfall on the other side of the next hill.

But before you can immerse yourself in the pleasures that lie ahead, another sound invades your consciousness. It's the sound of music! Music in 4/4 time with emphasis on the second and fourth beats; yes, it is unmistakably rock music — very loud rock music. And it is coming from the biggest damn boombox I have ever seen. Sitting around the raucous radio are a cluster of young people, most with beer cans welded to their lips. "Hi, there," I say. "Are you folks from around here?"

"No, man, we are from the day camp over in Bristolville. We got tired of that canoeing and crafts s... and came over here to get away from the nature crap," says the one camper not sucking on a beer but with a bottle of wine cooler in his hand.

"I see," say I, wondering at their obvious alienation from the real world. "How old are you kids, and is that really a battery-powered TV?"

"You bet it is, bikeman, and we are all old enough to watch it! The camp is for 12 to 16 year olds, and that is what we are."

"Have you tried walking along these beautiful trails and looking at the amazing things nature has to offer?" I say with not even a trace of naivete in my voice because I already sense that their alienation is beyond the influence of reason.

"Get serious, man," pipes a disheveled girl of about 14, "music is where it's at and moss gives me an allergy. It's MTV and Miller time in the country!"

"God," I reverently ask, "whatever happened to the natural highs of nature? Doesn't anyone want to know the names of plants and trees? Are the sounds of the forest not good enough any more? Is our vision to be narrowed to 5 to 25 inch, diagonal screens?"

I turn my bike around and head the other way; I cannot bear to pass through that generation gap.

I know that not all young people are so uninterested in nature but there are more of them than I ever guessed. Yesterday I passed a line of hikers who, each one, had headphones over their ears. Most had their eyes closed and their heads bobbed in 4/4 time. A blue heron swooped majestically into the stream on the hikers' right flank and not one of them saw or heard it.

This electronic separation from healthy reality surely cannot be conducive to a sensitive, environment-conscious society. It seems to be a subtle form of addiction that escapes the "say no to drugs" scenario. Let's be on the lookout for the "headphone sign." Perhaps we can rescue some of its victims before it is too late.

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
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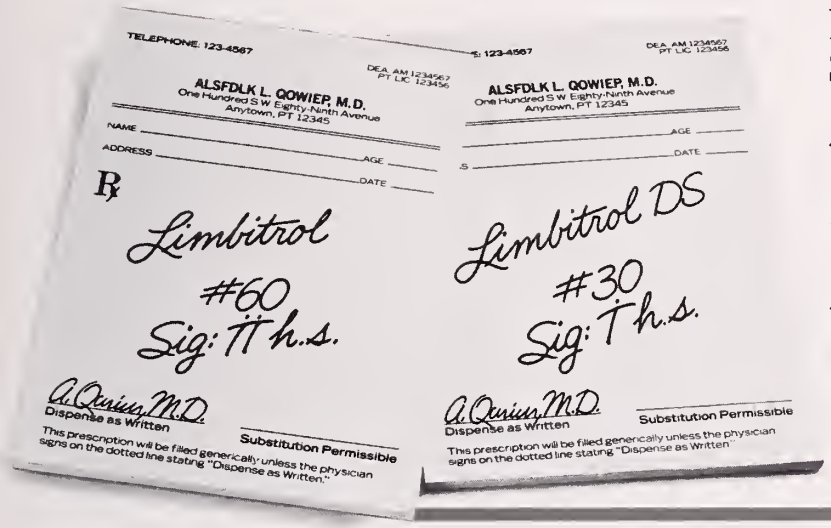

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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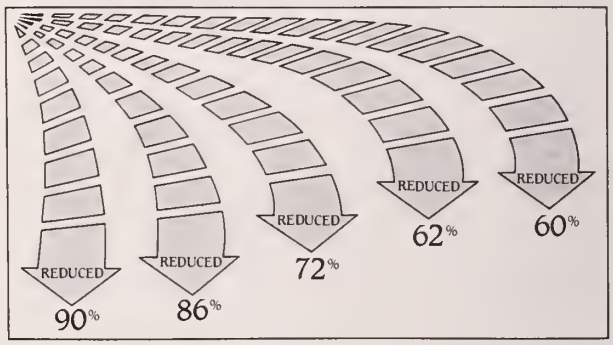

*Patients often presented with more than one somatic symptom.

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Yank D. Coble Jr., M.D.
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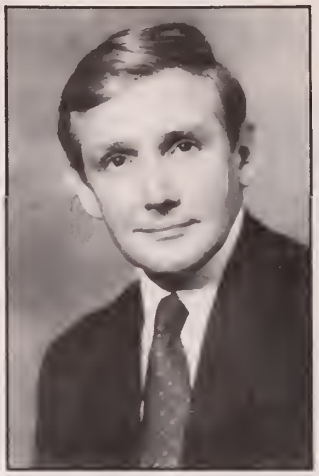

COVER

Yank D. Coble Jr., M.D., a Jacksonville endocrinologist, is FMA's 112th president. During inauguration ceremonies at last month's Annual Meeting, Dr. Coble told his audience that "quality and competence should continue to remain in the soul of the medical profession...." Dr. Coble has served nine years as a delegate to the FMA House of Delegates, five years as chairman of the Council on Scientific Affairs, and five years as FMA treasurer.

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1. Hopkinson JH III: *Curr Ther Res* 24: 503-516, 1978
2. Beaver, WT *Arch Intern Med*, 141:293-300, 1981.

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Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of material opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.
Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related.
The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total 24 hour dose should not exceed 8 tablets.

Revised June, 1987 5803

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Dear Colleagues:

The Bylaws of the Florida Medical Association state that our primary purpose is to promote the art and science of medicine and the betterment of the public health; however, my first personal communication to you in this scientific publication is by necessity non-scientific.

At the moment nothing is more critical to us as individuals or as an Association than the passage of Constitutional Amendment Number 10, a $100,000 cap on noneconomic damages, November 8th. It is important not because of what it will cost us if we fail, but what it will cost our patients and all the citizens of Florida.

Our success rate has been extraordinary when we participated aggressively and appropriately in the process. For example, you passed significant tort reform in 1975 when California and Indiana passed theirs. You obtained over 600,000 signatures on a constitutional amendment in 1984 that a district judge ruled was a single subject and clearly worded. You passed significant tort reform laws, including a cap on non-economic damages, in 1986. In each case the Florida Supreme Court ruled "unconstitutional" the efforts of Florida citizens, their representatives, and ourselves. If the laws passed in Special Session of our Legislature in February 1988 are effective, we have every reason to believe those too will be ruled unconstitutional.

Experts advised us over a year ago the fairest and most effective tort reform measure would be a constitutional amendment capping non-economic damages. While larger caps are present in many states and considered effective and have been ruled constitutional, a $100,000 cap was recommended in Florida. Actuaries believed a higher cap would not have a significant effect on rates and availability of insurance in a state so lacking in other effective tort reform measures. Only a small percentage of the difference between $100,000 and $250,000 would go to injured parties, thus the $100,000, though admittedly psychologically less attractive, is significantly more effective without substantially reducing the award to the injured party. In view of the recent defeat of pro tort reform legislators, it is unlikely that any significant tort reform will be passed or favorably received by our Supreme Court unless Amendment 10 is passed.

In September 1987 the FMA voted unanimously to assess each members $500 and to provide the citizens of Florida the opportunity to vote on Amendment 10. Supreme Court approval was obtained on the wording of the Amendment in March 1988 and the fund-raising you authorized began. By July 1988 sufficient signatures were obtained through the magnificent effort of our Auxilians and staff to place Amendment 10 on the ballot November 8th.

Our colleagues in Arizona whose amendment failed at 49½% to 50½% in 1986, and our professional consultants, believe that our success is now dependent on three things: 1) Dollars to fund media and other activities through 7:00 p.m., November 8th, primarily from our assessment (Arizona assessed $750 per member in 1986) and the funds you raise from hospitals, businesses, professional associations, etc; 2) Physician communication with patients in person or by letters and with visible demonstration of support such as buttons, signs, and brochures (the polls consistently show voters who are undecided will favor their physician's opinion over any other); 3) Physician, staff, family, and friends at the polls *all day* November 8th (the inclination of all citizens is

to ignore or vote "no" on constitutional amendments; thus a friendly "yes" communication at the polls November 8th is a vital reminder).

Despite the deceptive ads by Alert '88, the polls and the pros tell us the election is ours to lose. The curtain now opens on the last scene of the last act when the public will make their decision November 8th. Our success will provide enormous momentum for further reforms and positive action.

Perhaps ironically, the great burden of Amendment 10 also provides us an unprecedented opportunity — the opportunity to cure or to put into remission one of the most deadly ills of any organization — apathy. Apathetic men and women change nothing, accomplish nothing, and renew nothing, least of all themselves. We must give thanks for this wonderful professsion and country. We must share our vision personally with our patients and the public and convince them we care foremost for them. Only our personal involvement will assure success and the opportunity to get about the real business of our profession when we finish gathering together at the polls November 8th.

Frank D. Lobile, Jr

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued. In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 mg/24 hr system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 mg/24 hr system. Some patients, however, may require the Transderm-Nitro 10 mg/24 hr system. If a single Transderm-Nitro 5 mg/24 hr system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 mg/24 hr systems or one Transderm-Nitro 10 mg/24 hr system. More systems may be added as indicated by continued careful monitoring of clinical response.
The Transderm-Nitro 2.5 mg/24 hr system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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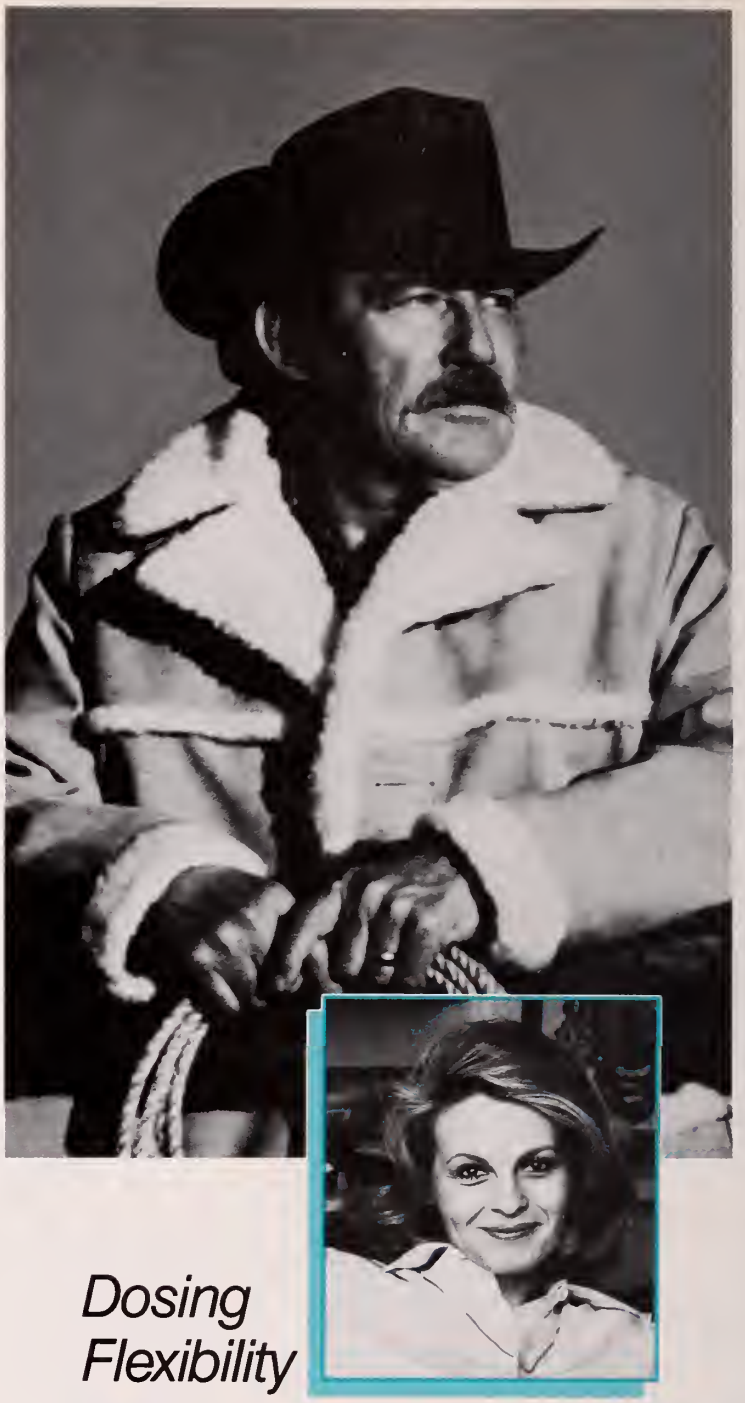
C I B A

References:
1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.



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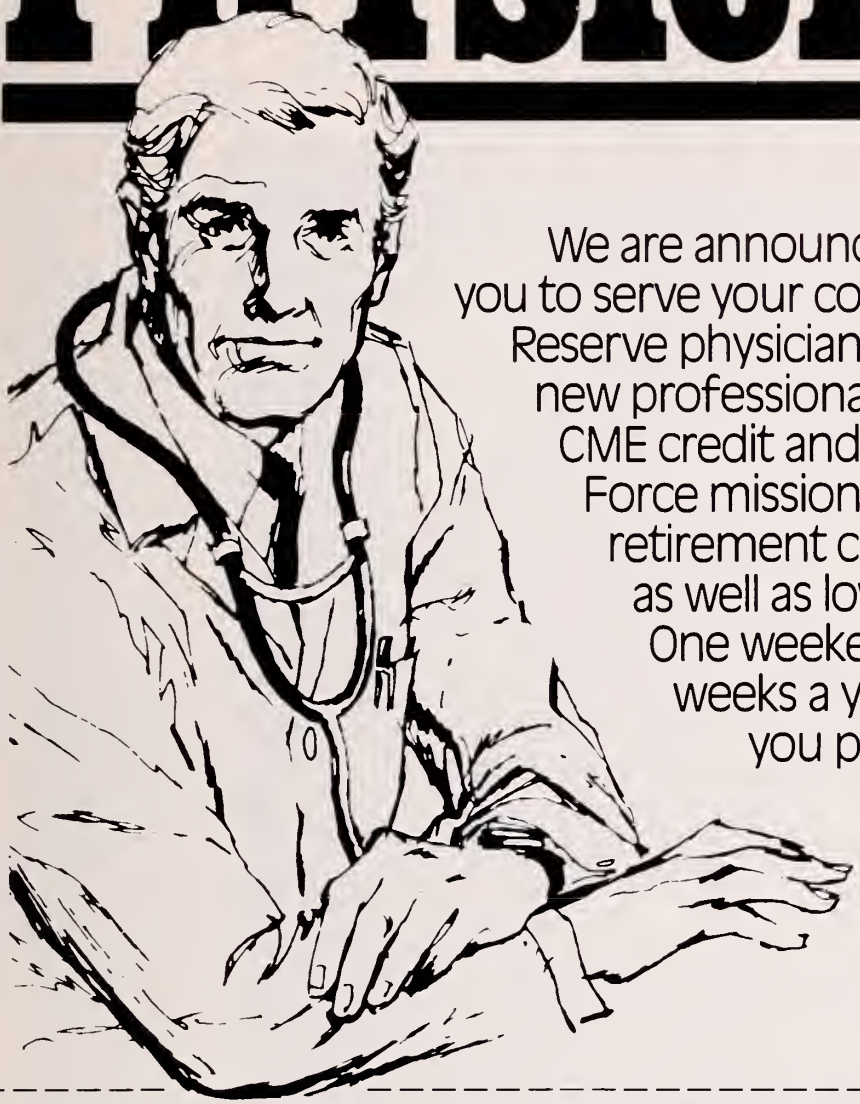

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EDITORIALS

Yank D. Coble Jr., M.D.

The 112th President of the Florida Medical Association is an articulate, intelligent physician whose youthful appearance and quiet demeanor belie his quick mind and competitive spirit, and frequently disarm those who would be an adversary. Coming from the North Carolina mill town of Burlington and having the name, Yank, led to harassment at times but very likely prompted him at an early age to develop the negotiating skills that have contributed to his great success in many medical and civic organizations.

In his youth he concentrated on academics and football which resulted in his receiving the highly sought Angier B. Duke scholarship to Duke University and achieving all-state recognition as a lineman playing both offense and defense. After completing undergraduate studies he entered Duke University School of Medicine where he initially demonstrated leadership abilities becoming student body president and Honor Council chairman.

Yank and his lovely bride from Jacksonville, Ohlyne Blackard, whom he met as a Duke undergraduate, were able to gratify their love of travel while advancing Yank's career development over the next few years. They moved to New York City and Cornell Medical Center for two years of internal medicine training; however, that was just the beginning for they then spent the next five years in Cairo, Egypt, and London, England, where Yank pursued his interest and studies in the field of nutrition. They then returned to the United States, stopping at the National Institutes of Health in Bethesda, Maryland, for one year and Nashville, Tennessee, where Yank served on the faculty at Vanderbilt University School of Medicine for another year before establishing his private practice of endocrinology and nutrition in Jacksonville.

Since his arrival he has been a whirlwind of activity, serving organized medicine and the community at large. He has held numerous offices in the Duval County Medical Society, culminating in his becoming president in 1969, while simultaneously participating in the educational and scientific arms of the Florida Medical Association, rising to chairmanship of the Council on Scientific Activities in 1977. In 1982 he was elected treasurer and then President-Elect last year.

Additionally he has served as president of the Florida Endocrine Society and Florida Society of Internal Medicine, on the Board of Trustees of the American Society of Internal Medicine, and in several American Medical Association positions, most recently being elected to the AMA Council on Scientific Affairs.

As if that weren't enough, Yank has been very involved in a number of civic activities: (1) JCCI, a Jacksonville organization that studies local civic issues and of which he served as president in 1979-80; (2) Leadership Jacksonville; (3) several Chamber of Commerce task forces and committees; (4) Bartram School Board of Directors; (5) Big Brothers, and (6) Jacksonville Arts Assembly.

It is remarkable that he has been able to accomplish all this and maintain a busy and successful solo practice, continue his hobby of collecting rare books, keep fit with a regular exercise program, and enjoy his family which includes in addition to Ohlyne, their two lovely daughters, Tinsley and Martelia. The Cobles have a beautiful old home in Seminole Beach that they share with friends and colleagues on many social occasions. Yank is obviously the Florida Medical Association's "man for all seasons," who will effectively represent physicians' principal interest which is to preserve their ability to deliver high quality health care to their patients. Although he will be FMA President for just one year, he will always be a gentleman and a scholar.

Charles P. Hayes Jr., M.D.
Jacksonville

Handwriting Is on the Wall for Trial Lawyers

The vicious campaign of lies, distortions, and deceit launched by Florida trial lawyers against Amendment 10 confirms what most people knew all along: the trial lawyers are running scared and they have run out of any plausible reason to defend a system that they have mercilessly exploited to the hilt. Now they have the audacity to insult the intelligence of voters and ask for their support at the same time!

I shudder to think that a group that purports to believe in fair play and justice and that ceaselessly talks about defending the constitutional rights of every American should stoop so low in a diabolical campaign to mislead and deceive the public.

Perhaps most Americans, familiar with trial lawyers and their ilk, are no longer shocked by dirty tactics during an election campaign. But the tragedy here is that the trial lawyers, apart from ripping the public off, have been able to seduce to their side a few respectable groups such as MADD and the NAACP. I am not sure that these groups know what they are into.

Everybody knows that Amendment 10 has nothing to do with drunken drivers, drug dealers, and toxic polluters — that is a pure concoction by the trial lawyers. Amendment 10 does not protect these criminals; it is the rotten system of justice we have that coddles these elements. CBS featured in its 60 MINUTES program last year a Florida lawyer who bragged about letting off the hook every client he had who was accused of drunken driving. And guess who the drug dealers from South Florida turn to when they also want to get off the hook? The most expensive lawyers that money can buy. All this is not to say that drunken drivers, drug dealers, and toxic polluters ought not to have legal representation, but simply to point out that the scales of justice can be manipulated by those who are paid well to defend these criminals.

Physicians believe in fair play and adhere to the principle that there are always two sides to an argument. Physicians do not believe, however, that these arguments should be conducted on the level of the gutter. The trial bar ought not to underestimate the intelligence of the voters; many of these voters, including non trial lawyers, have strongly denounced the sleazy tactics of trial lawyers in a mounting backlash against them. Equally important, trial lawyers ought to abide by established codes of professional conduct just like everybody else. Willful distortion of facts to mislead the voters is a flagrant violation of the lawyers' ethical code that merits the highest public contempt. When one considers that lawyers as a group are already near the bottom of the ladder in terms of public respect, it does not make any sense to erode further that marginal support by manipulating the issues.

Regardless of the outcome of Amendment 10, the campaign launched by the trial bar ought to provoke an inquiry either by the Florida Bar or by the Florida Supreme Court to find out if the trial lawyers deliberately distorted the truth in an attempt to hoodwink the public. If this is the case, either body ought to consider disciplinary sanctions, including disbarment where this is applicable. If neither is willing to do this, then the public should press anew its demand that lawyers be regulated under the aegis of the Department of Professional Regulation just like everybody else. This is to assure that lawyers are not insulated from public scrutiny and to insure that any professional misconduct or breach of ethics ought not to go unpunished.

The handwriting is on the wall for trial lawyers and the system that they represent. Amendment 10 will correct some inequities of the tort system without abridging an individual's right to sue for an injury and without emptying the pocketbooks of Americans. The current professional liability crisis can only get worse if enough voters get swayed by the intimidating tactics of the trial lawyers. But that is not likely to happen.

After Amendment 10 passes, the Florida Coalition for Tort Reform should get busy for another referendum in 1990 aimed at capping lawyer's contingency fees, similar to Proposition 106 that California voters will be facing next month. By limiting noneconomic awards and by capping the lawyers' hefty fees, we may finally be able to restore reason, order, and sanity to a system that has victimized the American public for so long.

R. G. Lacsamana, M.D.
Editor

The Public Is Smarter Than We Realize

Recently I was the object of an attack in a letter to a local newspaper. The letter was not addressed to me personally but as the president of our county medical society and peripherally as an individual physician. The writer of the letter did not identify himself other than by initials and the newspaper allowed this to be printed. The thrust of the letter was to attack all physicians who did not accept mandatory Medicare assignment and to imply that these physicians were charging exorbitant rates, did not care about the American public and were not giving anything back to society. As I read the letter in the newspaper I had several emotions. This first was anger, then a sadness and realization that the writer was symbolic of millions of Americans who do not understand Medicare and quite possibly do not want to understand Medicare. The more I thought about the letter the more I felt that it deserved a response from both a perspective of an individual physician and also as the elected president of the county medical society who spoke for the majority of physicians on the local level.

Accordingly, I answered this letter and tried to explain why the majority of physicians do not accept mandatory assignment. I explained that customary and prevailing was not always fair and equitable, that what Medicare said was a reasonable price for a particular service was sometimes far from reasonable. I explained the utter frustration in dealing with Medicare and resubmitting claims time after time and the amount of time spent on the telephone being switched from operator to operator, being put on hold and often receiving no answer to a legitimate inquiry. These certainly made sense to me and I wondered if it made sense to the writer of the letter and to the public who would read my response. I also pointed out in the letter that a more pertinent question should be asked, not why all physicians are not participants in the Medicare program, but why only a small percentage are. I also pointed out that over 70% of all Medicare claims in the state of Florida are accepted on assignment. This means that many physicians accept assignment who are obviously not participating physicians. It also means that physicians in many cases accept assignment on a case by case basis, based often on the ability of that patient to be able to pay his/her bills.

I submitted that letter to the newspaper and waited for what I felt would be hostile replies. Instead, after my letter was printed, I got many favorable responses and most of them came from the retirement community. Because of this, I have come to the conclusion that what I felt was complete hostility toward physicians who did not accept assignment to that perhaps many retired persons understand the frustrations of dealing with Medicare as well as physicians do. Accordingly, I am encouraged and strengthened by this fact. I may certainly be wrong and this is a small segment of the population to base my premise on, but if this is representative, there are many people of Medicare age who understand the plight of physicians in dealing with Medicare.

It is also comforting to realize that Medicare has not been able to pull off one of its intended aims. This aim is to pit the patient against the doctor and to paint all nonparticipating physicians as public plunderers and robbers of the village gold. I quickly hasten to say that I realize that there are certainly many Medicare recipients who may have this attitude, but on the other hand there are many who do not.

Since that letter, I have had several conversations with retirees and they have all voiced their opinion that the problem with the Medicare system is not the physicians nor the patients, it is the Medicare system. It is not the concept of Medicare, which is to care for the segment of the population over 65 and to provide quality medical care, it is simply the bureaucratic bungling that has pitted physician against patient in an attempt to achieve a budget bottom line for HCFA and Medicare.

The Congress of the United States would better serve its elderly patients and the intended purpose of Medicare if it would examine and correct the gross inefficiencies that exist within the system. Instead Medicare has opted to put out disincentives to nonparticipating physicians and to try to convince the American public that a nonparticipating physician is somehow a ghoul who feeds on American society. Alas, this perspective may be playing well in Washington, but it is not playing well in the hinter-

lands of America. There may be millions of Medicare recipients who still believe that physicians are at fault for the inequities in the medical care system, but there are many converts to the idea that physicians are often pawns in the game just as they are. When enough Medicare recipients realize this, there would then be considerable pressure on Washington to correct the system as it now stands.

I dare say there are not many physicians who are critical of Medicare as a concept. There are not many Americans who would now say that Medicare as an idea and as a humanitarian gesture is not a positive virtue. However, there are many responsible people including physicians, Medicare recipients, ethicists, economists and others who will state that Medicare has not fulfilled its promise to the American people. This promise can only be fulfilled by looking at the structure of Medicare, at the entire payment system and correcting the inequities that exist for both the patient and physicians who participate in the Medicare program. Only at that time will physicians and patients blend into a harmonious whole and work together within the system to provide the quality medical care that all Americans deserve and should be provided.

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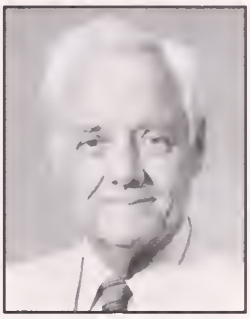

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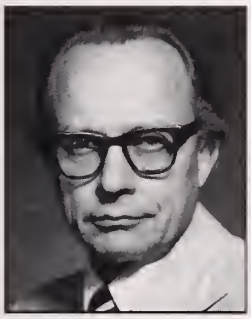

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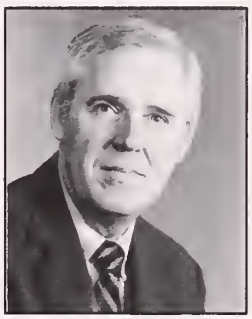

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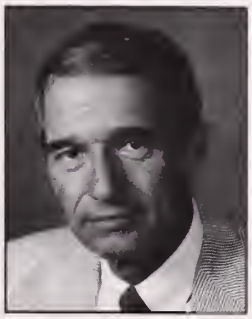

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ANNUAL MEETING HIGHLIGHTS

GOODBYE TO HOLLYWOOD. The Diplomat Hotel in Hollywood may have seen the last of the annual FMA meetings to be held inside its premises. The once regal hotel, which has hosted most of the FMA meetings for the past ten years, has slowly lost its luster and attraction. FMA delegates who have been agitating to relocate the Annual Meeting finally got their wish: the 1989 meeting will be held at the Orlando Marriott which has a capacity of close to 2,000 rooms. The proximity of the meeting to Disney World and other tourist attractions may boost attendance figures although room rates at the Marriott will carry a steeper price.

JACKSONVILLE OR TALLAHASSEE? One of the most hotly debated issues at the September Annual Meeting was a proposal to consider relocating FMA headquarters from Jacksonville to Tallahassee. The impetus for this move was the belief that a significant number of issues affecting medicine are being fought in the legislative chambers, and that Tallahassee would offer instant proximity and perhaps better clout for the FMA in fighting for its interests. Although the proposal won considerable backing, particularly from South Florida physicians, the House of Delegates voted it down after hearing arguments from both sides. The logistics of relocating the whole FMA operations, costs of the move, certain loss of income from disposing FMA assets in Jacksonville, and potential loss of most key FMA personnel who form the backbone of the FMA office carried the day for staying put in Jacksonville. The House instead voted to establish a stronger presence in Tallahassee by enlarging the office there and employing more personnel as well as consultants.

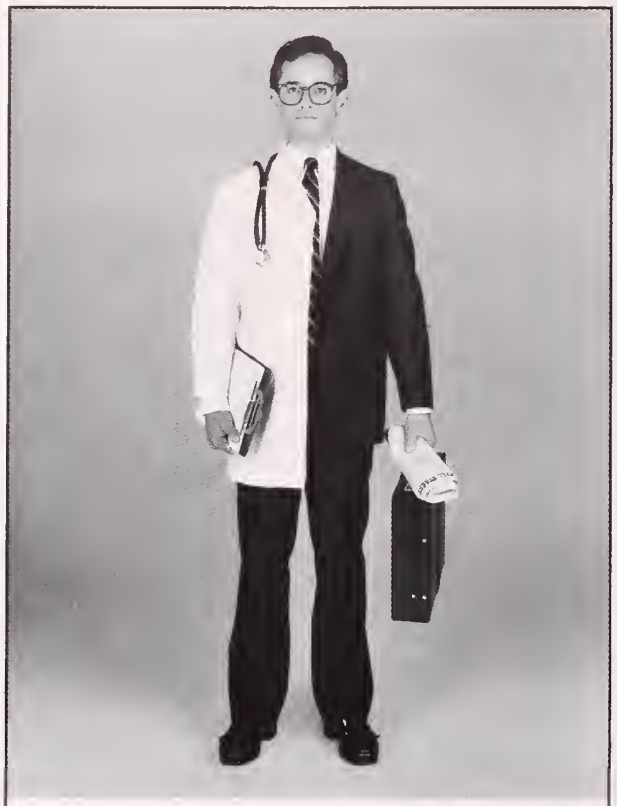
TALES FROM THE WHITE HOUSE. Hugh Sidey, a contributing editor to *Life* and *Time* magazines, delivered the annual Abel S. Baldwin Memorial Lecture before a jampacked, enthralled audience in the Les Ambassadeurs Room. Sidey, who has been covering the White House beat since Harry S. Truman, gave vivid, often humorous accounts of the past seven American presidents, offering insights into their personalities, character, peccadilloes, strengths and weaknesses, and potential places in history. He described Reagan as the happiest man in Washington even when everybody else may be gloomy; further, he felt Washington will miss the Gipper quite badly when he steps out of the White House in 1989. He also made the bold prediction that Bush will win the election. Sidey did not say whether he is a card-carrying Republican or not.

QUIET ELECTIONS. The only contested election at the FMA meeting this year was that for a seat on the Board of Governors between Richard Bagby, M.D., of Orange County and Peter Tomasello, M.D., of Broward County. Dr. Bagby won in a close race. Although the preelection campaigning was hectic and spirited, both candidates were gentlemen all the way. Dr. Bagby is past president of the Orange County Medical Society and also serves as chairman of the FMA Membership Committee.

NEW BYLAWS CHANGES. New bylaws adopted by the House of Delegates will limit the terms of FMA officers to no more than three consecutive terms, the sole exception being the treasurer who can keep watch over the FMA's coffers for five years. Additional changes will also increase representation on the Board of Governors by 1989. The primary reason for the changes is to encourage increased participation in FMA leadership, particularly among younger physicians, and also to erase the perception that there are fossilized cliques within the upper hierarchy in the FMA. Even as these changes were adopted, numerous delegates also appreciate the fact that many physicians have held offices in the FMA for many years and have continued to be invaluable with their experience and expertise.

VOICES FROM THE YOUNG ONES. Medical students, residents in training, and young physicians made their presence felt strongly in this year's meeting. Each group sponsored its own program and introduced a number of resolutions to the House of Delegates. Students held a symposium touching on the increasing risks of medical practice as well as on the changing policies and directions of health care, while the residents had a program on the personal hazards of residency training and entry into practice. Young physicians, on the other hand, heard a program on personal and financial management for physicians just entering practice.

WELCOME TO THE FIRST LADY. Jane Eberly of Lighthouse Point took over the reins of the FMA Auxiliary succeeding Betty Orr of Tampa. Jane is the wife of Dr. Arthur Eberly, FMA Vice Speaker. Congratulations, Jane!



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Newsletter Format —

First Place — Cap Scan — Capital Medical Society

Second Place — Marion County Medical Society Bulletin

Magazine Format —

First Place — Miami Medicine — Dade County Medical Association

Second Place — On Call — Palm Beach County Medical Society

CATEGORY II — MOST IMPROVED BULLETIN

First Place — The Bulletin of Brevard County Medical Society

Second Place — Jacksonville Medicine, Duval County Medical Society

CATEGORY III — BEST EDITORIAL

First Place — Cap Scan — Capital Medical Society — "Empty Lockers"

Second Place — Miami Medicine — Dade County Medical Association — "My Son, An Organ Donor"

Second Place — PICOMESO Mail Bag — Pinellas County Medical Society — "Of Course There's a Malpractice Crisis But Is The *St. Pete Times* For Real"

Special Recognition — Marion County Medical Society Bulletin — "From The President"

Special Recognition — Miami Medicine — Dade County Medical Assn. — "What Ob/Gyn's Now Must Face"

CATEGORY IV — BEST REGULAR FEATURE

First Place — Central Florida Physician — Orange County Medical Society — "FBM Brief"

Second Place — The Bulletin — Hillsborough County Medical Association — "President's Page"

Special Recognition — Cap Scan — Capital Medical Society — "Med-Law"

CATEGORY V — SPECIAL RECOGNITION

First Place — Central Florida Physician — Orange County Medical Society — Sports In Medicine Issue

Second Place — Cap Scan — Capital Medical Society — April Fools Issue

Second Place — On Call — Palm Beach County Medical Society — September, October and December 1987 issues

Oscar Time in Hollywood

The editorial staff of *The Journal of the Florida Medical Association* hosted the Editor's Luncheon on September 8 with the editor, R.G. Lacsamana, M.D., giving out the awards to the winners in the annual County Medical Society Bulletin Contest.

Competition this year was quite keen, as it has been the past few years, with a record number of entries and with many of the publications appearing in new, beautiful designs, with dazzling layouts, vivid colors, and stimulating articles, editorials, and commentaries about medicine and everything else.

Calvin R. Peters, M.D., Pres.-Elect, Orange CMS, receives award on behalf of the *Central Florida Physician* from R.G. Lacsamana, M.D.

Listen to what one of the judges, Dale Havre, M.D., had to say about the contest:

"The deed is done! My eyeballs feel as if little wires inside them have been tightened by nuclear powered pliers. My head is filled with a potpourri of superb writing, glorious covers, and layouts that would put the plans for our nation's capitol to shame. It has been a tough job, but I have done it and I have survived — barely. Being a judge for the 1988 County Medical Society Bulletin Contest has been a humbling experience. Within those thoughtful journals, I have met so many men and women of exceptional intelligence, sensitivity and expressivity that I shall forevermore cringe as I attempt the smallest of literary tasks.

I want you to know that I read every competing article and editorial, looked at every page of each newsletter and bulletin and scrutinized all pictorial material. I must admit that even though it took me a week to do it, it was a labor of love. I soon discovered that *all* the publications deserved to be winners. Trying to pick the best among these entries is like arguing about which saints are holiest. Objectivity can be attempted, but in the end you just have to pick with your heart."

(See previous page for complete list of winners.)

Cap Scan Editor, Charles Moore, M.D., and Mollie Hill, Managing Editor, with awards presented to *Cap Scan*.

Jeffrey S. Hammond, M.D., Editorial Board member, and Odalys Mesa, Communications Coordinator display the awards won by *Miami Medicine*.

On Call Editor Richard Hays, M.D., and Sue-Ellen Apte, Executive Vice President, with awards won by *On Call*.

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Compression Therapy, George Johnson, Jr., M.D.

Lymphedema, W. Andrew Dale, M.D.

Laboratory Evaluation of the Swollen Leg, William Blackshear, M.D.

Treatment of Primary Varicose Veins: Sclerotherapy and Operations, George Johnson, Jr., M.D.

Venous Reconstructive Procedures, W. Andrew Dale, M.D.

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LETTERS & VIEWPOINTS

What's in a Name, Doctor?

"I have everything when I have named the man," Pliny the Younger stated in A.D. 98. Many people might agree. After all, naming someone or something remains the distinctive prerogative of *homo sapiens*. Through speech we communicate, whether for such fundamental needs as obtaining food and water, or for determining the whereabouts of an unknown toilet, or for exchanging intellectual issues. Through wearing name tags at meetings, for example, we gain a heightened reality even standing in an otherwise anonymous crowd. In short, *Nomino ergo sum*.

Yet through naming we do far less than say everything (*pace* Pliny the Younger); and that reality warrants comment, especially where medicine is concerned.

Now there might have been a time when everything was indeed said in naming. "As his name is, so is he," one character in the Bible declares (I Samuel 25:25) in an effort to discredit an opponent whose name means fool in Hebrew. In other cases, physical features might identify the person: Cyclops, for example, literally meant round eye in Greek; Oedipus swollen foot; Paul came from the Latin word for little. Social attributes might be important: brave individuals might be called Doughty, Prowse, Lyon, Bould; the cunning known as Fox, Todd, or Pratt; the wild Haggard, Wildblood, or Willgoss.

Prospective parents are probably more aware of the power of naming because of the number of baby books on the subject. One author warns that in naming your child you will determine social acceptance or rejection. In effect, by thy name ye shall be known. Sobering advice for those selecting common names like John and Mary, or opting for more esoteric nomenclatures like Alake ("One to be petted if she survives," in Nigerian) or Tem ("country," from the gypsy language). Still another provocative study suggests that if parents wait to name their neonate by what it looks like, and it is a boy, there is a greater statistical likelihood it will be named George. No explanation, by the way, is given for this phenomenon.

Yet the naming of persons and things has assumed an increasingly different form in medical circles. In the first place, patient's names have given way to reference numbers in many cases. Secondly and more importantly, a patient's name and even number are really ancillary to the greater medical fixation on diagnostic naming.

But what's in a diagnostic name? And has everything been said when the patient's condition has been identified? No less a philosopher (and hypochondriac) than Immanuel Kant once grumbled, no doubt after a medical consultation, that "Physicians think they do a lot for a patient when they give his disease a name." He, like many other patients through the centuries and especially today, aren't convinced this constitutes good medical practice.

Many patients complain of hearing medical gobbledygook, MEDSPEAK, or obscurantism. In the simplest of cases, the doctor speaks of a patellar reflex instead of a simple knee-jerk. With more complicated and serious diseases, pathological descriptions such as "infiltrating and intraductal carcinoma" may be provided which would frighten even the most learned German philosopher, let alone bus driver, if they were said with the uncaring passion of a character in a poem by T.S. Eliot when he remarked that

I gotta use words when I talk to you
But if you understand or if you don't
It's nothing to me and nothing to you
We all gotta do what we gotta do.

Even the most painstakingly sympathetic physician may still well indulge in medical jargon and technical terms. Considering that the average length of time of a medical consultation to convey "bad news" is only between 30-45 minutes, and that patients retain less than 20% of information, however accurate or inaccurate, the task is admittedly difficult.[1] It is also compounded by whatever personal and professional feelings the physician has about rendering a diagnosis, and especially a difficult one.

When the physician comes to name a disease, however serious, due verbal caution must be exhibited at all times. For physicians are not meant to be the medical equivalent of High Court judges rendering a sentence (or just a word) — "You have cancer" (or motor neuron diseases, AIDS, Parkinson's, or whatever) — and then leaving the prisoner of the body to his or her fate. In fact, the words used may be more important or potentially therapeutic (or lethal) than any other medical means used for treatment.

Naming may have tremendous psychological ramifications. Certainly some patients can be immensely relieved when their condition is at last identified, even if it is indeed serious. At last they "know" what is the problem. Yet if the diagnostic naming is poorly done, then the patient may experience untold suffering, especially if they don't particularly under-

stand what is being said. They may only hear certain words — malignant, bad, serious, ugly, and cancer — and not put them into proper context. If a child is involved, the use of one particular descriptive word, however used, may linguistically scar for a lifetime. ("The doctor years ago said I had an ugly nose" — when in reality the physician said she had an ugly bump on her nose.)

Naming also may do nothing to assist the patient unless the words are heard and understood. It is therefore important to ensure the information has been correctly grasped, even if it means several consultations. More importantly, the patient must realize that medical naming doesn't say everything; and that precisely at this point the art and science of medical care truly begins and ends.

Jonathan Sinclair Carey, STM, DPMSA
London

Reference

1. Taylor, K M · Telling Bad News: Physicians and the Disclosure of Undersirable Information, Sociology of Health and Illness: Journal of Medical Sociology, June 1988, pp 109-132.

An Additional Viewpoint: What Went Wrong With Nursing?

Dr. Samartino's response to your editorial published in June hit me as a committed nurse where it hurts. Your readers should, perhaps, hear from someone seeing it from the inside of the nursing profession.

Regarding nursing education. In my mother's era (she was a nurse in the 1920s) a "good nurse" was a private duty nurse, caring for a patient at home with daily housecalls by the physician. The hospital had little more to offer the acutely ill patient by way of technology.

The development of increasingly high technology in medicine has required nursing to become "high tech" as well as "high touch." At this time, no nursing program can prepare a nurse adequately to function at high proficiency in all specialty areas and acuity levels. The most we can aim for is a basis in the sciences; orientation to the environments where we find our patient groups; and observational, communication, and basic psychomotor skills, in addition to the essential normal and pathological physiology and anatomy. It has been 20 years at least since baccalaureate nursing programs were considered preparatory schools for nursing supervisors and educators. Now the B.S.N. is considered necessary but not sufficient for administration or nursing education. The A.N.A. and other organized nursing groups have adopted the B.S.N. as the entry level preparation for licensed professional nursing. What the highly educated ("overeducated?") nurse brings to her first clinical position is the academic background to learn and clinical sophistication to adapt to changing technology.

Orientation by the employer of all new nurses is simply on-the-job-training which any new employee, especially one new to a profession, expects. New MBAs aren't "turned loose" in banks to manage large amounts of other people's money without a mentor, nor do new medical school graduates practice sophisticated medicine without long apprenticeship.

Regarding the Nursing Shortage: Throughout my nursing career, shortages of nurses have come and gone. Nursing schools of all degrees "turned out" class after class of highly motivated and bright young women, many of whom soon "burned out" and retired away from hospital nursing to motherhood or to other occupations. Band-Aid solutions, as Dr. Samartino calls the development of LPN, associate degree programs, etc., have helped, as did various financial aid programs funded by the federal government. The current shortage, however, is more critical mainly because recruitment for the current classes has become a serious problem despite a continued wide variety of "entry-level" preparation programs and continued funding of these programs. There are two major reasons for the recruitment problem.

A. Brain Drain: In earlier periods, the options for a bright young woman were very limited. In 1961, as an undergraduate, I was told by the Dean of Women (kindly and with a straight face) that women were not wanted in medicine because they had short careers and would not contribute long term to the support of the medical school. Needless to say, changing social structures have caused many other financially rewarding professions to open up to women. And women now anticipate a continuing need to support themselves and possibly a family.

B. The P.R. Problem: Television is now the major educator of young people, and has been for many years. The nurse on TV has most often been portrayed as a bit-player in the drama of medicine. She is the silent professional, cool and rigid, standing behind the desk handing the chart to the physician. She is carrying a clipboard and passing by in the corridor as the physicians discuss the cases. She is even invisible as the doctor (now, often a woman) is seated all night by the bedside of the critically ill patient along with the family. (I intend to market a bumpersticker — "Marcus Welby was a nurse!") She is the good-hearted bad girl — as Margaret "Hot-Lips" Houlihan in the early *M.A.S.H.* episodes.

The opportunity to be part of the critical moments in lives of patients and families and to make a difference in their ability to cope is what has always

drawn people to nursing and kept them. Television has, for the most part, robbed nursing of this image.

What are my suggestions for nursing now? They are not revolutionary nor easily accomplished.

1. Higher salaries will address both problem areas listed above.

Like it or not, financial remuneration will increase the respect that nurses are given by the public and increase recruitment and especially retention. Beginning salaries for nurses recently have become fairly reasonable in comparison to some other occupations. I, however, after 24 years as a nurse, with an advanced degree, and having held responsible positions, am disconcerted when a young nurse (such as my niece recently) asked me my salary. It is much less than double her starting salary and we are both embarrassed. If I were responsible for the support of my family as are most active nurses my age, I would be angry as well as embarrassed.

2. Nurses must support their organizations and unite behind a single educational entry level-baccalaureate degree—not excluding presently practicing competent nurses, of course. The Patient Care Technician proposed by the AMA is only the newest Band-Aid solution. It will not solve the current shortage unless employers intend to substantially increase the career benefits of the new category of health care giver far beyond what nurses enjoy. Interestingly this has united nurses behind the "Entry-level B.S.N." like nothing before during its long and dragged-out history.

3. Nurses and physicians have, by the nature of the needs of patients, been partners professionally. Caring and curing functions are interdependent and overlapping. This will continue despite the occasional independent nursing practice and despite increased ambulatory care surgery, and DRGs.

Let's not decide for one another what is wrong with our professions but support and help one another for the benefit of our clients and ourselves.

Janet S. Tompkins, R.N.,M.S.
Miami

Waste in Medicine

The recent article by Robert Seligson on mandatory assignment was right on the mark. The federal government continues to look for ways to save nickels and dimes while wasting millions in Medicare and Medicaid programs.

Two examples of such waste:

When I entered private practice nine years ago, billing for electrocardiograms and similar procedures was done by the hospital directly. The billing included both the technical component charge and the physicians' interpretation charge. I was paid about $10-$11 per ECG interpretation. Then Medicare insisted that the physicians' component be separated from the technical and billed directly.

Now that the interpretation fees were to be billed separately, it became necessary to add a billing fee and allow for bad debts. Unfortunately most patients will ignore a bill for such small amounts, especially when the name of the doctor is unknown to them. So the fee charged for interpretation more than doubled. If one considers that the average hospital bill has many items for clinical pathology, radiology, nuclear medicine, etc., the additional billings are sizable, and all the result of governmental ruling to insist on separation of Medicare A & B charges.

The second area of waste is a more difficult one. Our medical system treats every patient as deserving of every possible procedure without consideration of the patient's role in his own health care. For example, we should insist that a patient stop smoking, lose weight and enter an exercise program before a coronary artery bypass procedure is considered.

While this latter would amount to "rationing" of medical care, I believe it a worthwhile alternative to the present method of reducing physicians' fees while increasing the amount of paperwork for each procedure.

L. Jerome Krovetz, M.D., Ph.D.
Plantation

Doom and Gloom in Medicine

It makes me very sad (a physician in practice here 35 years) to read about an increasing number of physicians who are bending to the yoke of the government and accepting the pittance Medicare allows by participation in assignment acceptance for all patients.

In my years in practice, I have donated considerable free care either because I did not charge or because I was cheated. I do accept Medicare assignment on a selective basis as indicated. But I resent having to accept allowances from Medicare on patients who earn or possess sufficient money to pay for well earned services.

An article in "Florida Medical Business" pointed out "that more doctors are accepting participation because of the recognition of the financial needs of their patients."

The real reason behind this participation is the chronic mental fatigue caused by constant harrassment, and the fear that patients will stray to participating doctors.

Slowly over the years, I have observed the medical profession become more and more enslaved by the government and insurance companies, and many doctors have contributed to this trend, as they have also in joining HMOs. They are not leaving much legacy to the few offspring who may wish to pursue a medical career.

In addition, medicine is becoming the profession of procedures because that is where the money is.

The increasingly poor comradeship between doctors makes me again very sad. I have no axe to grind, for my own interest, since progressive cardiac disease may force me to retire. I doubt that the above will have any impact, but it has helped to ventilate my feelings.

It is sad that many physicians cannot see what the future holds because of their need for current gratification. I liken them to those who are not interested in environmental control, both here and throughout the world, those who are interested only in building larger and larger malls, and overdevelopment, squeezing our wildlife into extinction.

We even have doctors who enjoy destroying wildlife for sport. To those, I would say: take up boxing, karate, or mountain climbing, if you need some thrill, or a need to ventilate hostility or brutality.

Well, one could go on indefinitely.

Gaetano A. LoPresti, M.D.
Ft. Lauderdale

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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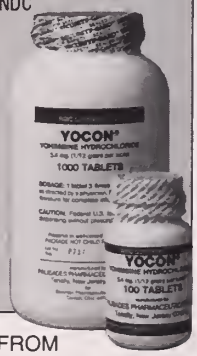

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Primary Nonepithelial Lesions of the Lung: A Ten-Year Community Hospital Experience

Frank M. Taylor III, M.D.

***ABSTRACT:* Although epithelial neoplasms are the most common primary tumors of the lung, lesions arising from the mesenchymal components do occasionally occur. In light of this, a ten-year span of surgical pathology records was reviewed and 23 primary nonepithelial lesions of the lung were documented. Discussed are the categories of tumors identified, their salient diagnostic features, and clinical courses.**

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While carcinomas of the lung appear to be presenting with increasing frequency, it is easy to overlook the fact that the lung is the site of other primary tumors. In a ten-year period, we encountered 23 primary nonepithelial tumors of the lung. The breakdown includes 14 hamartomas, five lymphomas, two pulmonary blastomas, one fibrous histiocytoma, and one leiomyosarcoma.

Hamartomas • The most commonly identified tumor was the hamartoma, 14 having been recorded. Histologically pulmonary hamartoma displays an unbalanced expansile growth which includes both mesenchymal elements (cartilage, adipose tissue, fibroconnective tissue, and smooth muscle) as well as epithelial components (bronchial and alveolar epithelium)[1,2] (Fig. 1).

For unknown reasons, these lesions appear to be much more frequent in men than in women, multiple series reflecting a 3:1 male/female ratio.[2,3] They are usually asymptomatic and most often present as a nodule on routine chest x-ray. Malignant change is virtually nonexistent.[3]

Our series of 14 cases paralleled the expected middle to older age range,[2,4] the ages ranging from 41 to 74 with the mean age being 63. A definite male preponderance was noted, nine patients being male and five female. None of the 14 cases exhibited any symptomatology referable to the hamartoma. In each case, the lesion was found in the course of being worked-up for another condition. Interestingly, four of the hamartomas were found in lungs with concomitant bronchogenic carcinoma. And on a related note, 12 of the 14 patients were moderate to heavy cigarette smokers.

Local resection is the treatment of choice for these lesions and was performed in all 14 cases with no recurrences.

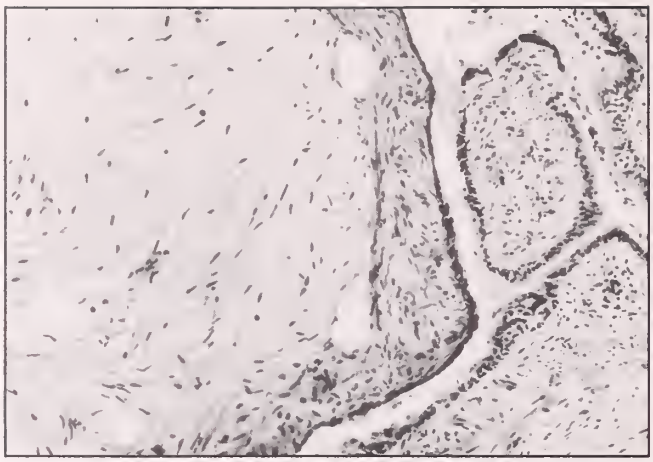

Fig. 1.—The mesenchymal (fibroconnective and adipose tissue) components distort and attenuate the entrapped simple columnar epithelium. (101x, hematoxylin and eosin).

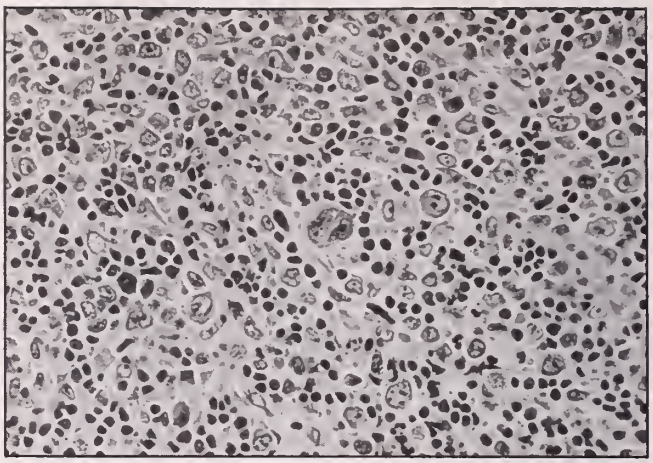

Fig. 2.—A central diagnostic Reed-Sternberg cell is surrounded by a mixture of lymphocytes and atypical histiocytes. (256x, hematoxylin and eosin).

With thin needle aspirations of the lung becoming more commonplace, the possible diagnosis of pulmonary hamartoma must always be borne in mind. The pale chondroid matrix and sparse cellularity can lure the cytopathologist into a false sense of bewilderment if he is anticipating a more cellular lesion.

Lymphomas ● Five patients were diagnosed with primary lymphoma of the lung. Of these, three were categorized as non-Hodgkin's lymphomas, one as Hodgkin's disease, and one as lymphomatoid granulomatosis. As expected, the literature reflects a paucity of primary extranodal lymphomas, particularly of the lung. Freeman and coworkers document that only 3.6% of extranodal lymphomas arise primarily in the lung, pleura, or trachea.[5]

One of the largest single series of pulmonary non-Hodgkin's lymphomas is that from the AFIP in 1982 by Koss and coworkers who report 130 cases. Among these, the small lymphocytic and plasmacytoid lymphocytic lymphomas predominated, accounting for over 60% of the total. Large cell lymphomas (including large cleaved, large noncleaved, and immunoblastic sarcoma) comprised less than 10%.[6] Two smaller series, one by L'Hoste and another by Peterson, show similar porportions.[7,8]

Histologic type appears to be a great predictor of survival, small lymphocytic and plasmacytoid lymphocytic lymphomas exhibiting the most favorable prognosis. L'Hoste and Koss both report a five-year survival among these types of about 80%. Conversely, large cell lymphomas imply a significantly worse prognosis, five-year survival appearing to be in the range of 35%.[6-8]

Clinically pulmonary lymphomas are usually heralded by cough, dyspnea, and upper respiratory infection. Hilar adenopathy is rarely observed. The most prognostically important radiologic feature is pleural effusion, which parallels cell type in its predictability of rapid recurrence and mortality. Ratio between sexes is even, and age distribution peaks in the seventh decade.[6-8]

Among our three cases, two were present in men, one in a woman. The ratio according to cell type was inverse to that reported in the literature, two being large cell and one small lymphocytic. As would be predicted, the patients with large cell lymphoma did poorly, both dying within one year of diagnosis. The patient with the small lymphocytic lymphoma is currently alive and well, though only one year post-diagnosis.

Primary Hodgkin's disease of the lung seems to be less common than its non-Hodgkin's counterpart, Whitcomb reporting one of the larger series with 29 eases.[9] Presenting symptoms and radiographic features are similar to non-Hodgkin's lymphomas of the lung.[10]

Our one case of Hodgkin's disease involved a 42-year-old black female who gave a history of a chronic nonproductive cough and night sweats. At surgery, a right upper lobe lesion was identified and biopsied (Fig. 2). Following definitive diagnosis, the patient was treated with radiation therapy. One year after surgery she is free of disease.

Our final lymphomatous pulmonary lesion is lymphomatoid granulomatosis. Liebow and coworkers first described lymphomatoid granulomatosis in 1972 and since then roughly 200 cases have been reported in the literature.[11]

This lesion is similar to lymphoma in its overall lymphohistiocytic composition but differs in the variety of cellular components. The composition is a mixture of mature lymphocytes, plasma cells, histiocytes, and large immunoblast-like cells referred to as atypical lymphoreticular cells by Leibow. The proportions of the various cells vary with each case.[11]

The most unique histologic feature is its prominent vascular involvement demonstrated by dense infiltrates involving the entire thickness of vessel walls with resultant narrowing (Fig. 3). Despite the density

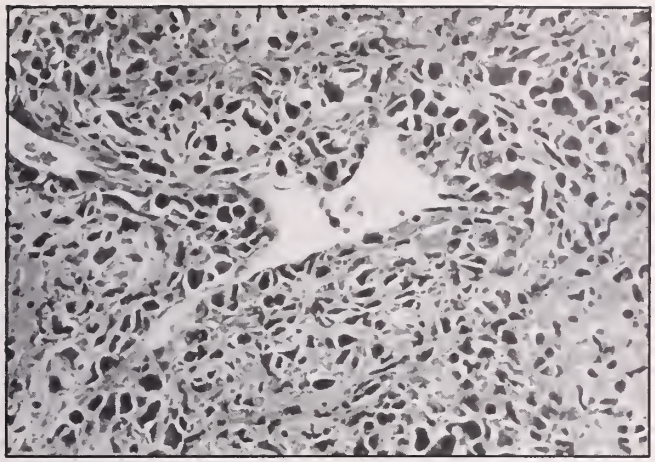

Fig. 3.—Atypical lymphohistiocytic infiltrate surrounds a branched vascular structure. (256x, hematoxylin and eosin).

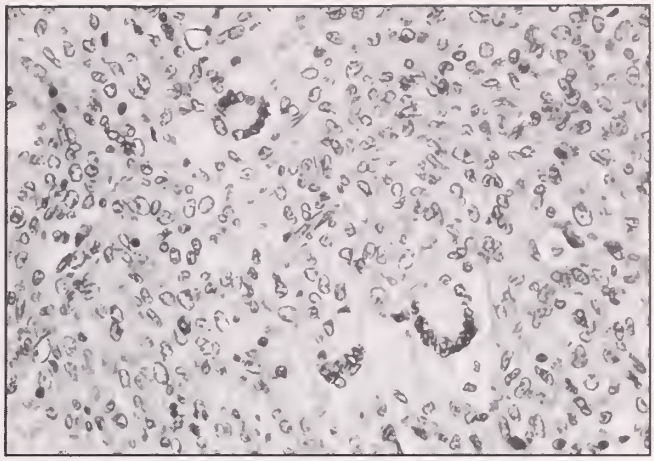

Fig. 4.—Background fibrous and histiocytic composition surrounds multiple multinucleated giant cells. (256x, hematoxylin and eosin).

of the inflammation, there is general absence of vascular necrosis. And in spite of the name, no true granulomas are formed.[11]

Clinically these patients are commonly males and present with symptoms referable to the lung such as cough and hemoptysis as well as prodromal systemic features such as fever, weight loss, skin rash, and neurologic signs. Lymphadenopathy may be present. About 70% will go on to death within two years because of progressive pulmonary destruction and extra-pulmonary spread.[12]

The relentless course of this disease has caused researchers in recent years to reexamine the nature of the condition. There seems to be mounting evidence that these cases actually represent a form of T-cell lymphoma.[12]

Our patient was a 61-year-old male who presented to his physician with a two month history of arthritis in the wrists, elbows, knees, and feet. He was also bothered by a worsening pain in the middle of his back and a rash over his upper chest.

On chest x-ray a 3 cm nodule was noted in the posterior basal portion of the right lung. Following biopsy, the patient was treated with cytoxan and prednisone. He is now 16-months postdiagnosis without disease.

Fibrous histiocytoma ● Fibrous histiocytoma is a neoplasm arising from a primitive mesenchymal cell which differentiates toward both fibroblastic and histiocytic lines. It is most commonly found in the soft tissues of limbs and torso and in its malignant form is now recognized as the most common sarcoma in adults.[13]

Pulmonary fibrous histiocytoma is an unusual lesion which, because of its location and unexpected cellular composition, poses difficult diagnostic problems. Histologically the lesion consists of a spindle cell component as well as a more plump histiocytic element. The cytoplasm is generally eosinophilic; the nuclei moderately basophilic, oblong, and sometimes grooved. Scattered collections of multinucleated giant cells are present which often contain a pale vacuolated cytoplasm (Fig. 4).

Perhaps the most difficult problem diagnostically in these lesions is the differentiation of benignity from malignancy. Histologic features favoring a malignant diagnosis are high degree of nuclear atypia, high mitotic index, atypical mitotic figures, necrosis, and vascular invasion.[13]

Pulmonary fibrous histiocytoma was first described in 1957 by Bates and Hull and since then only 12 additional cases have appeared in the American literature. Six of these were in children but the age span extends from 18 months to 60 years. In the limited number of cases found in the American literature, pulmonary histiocytomas have shown local aggressiveness but have been reported to metastasize in only one instance.[14]

Our case arose in an eight-year-old white female who complained of anterior chest pain. A chest x-ray demonstrated a left lower lobe nodule. The patient was treated surgically by lobectomy and is alive and well without recurrence three years later.

Leiomyosarcoma ● Leiomyosarcomas along with fibrosarcomas are among the most common primary sarcomas of the lung, though they are still quite rare. Fewer than 100 cases have been reported. The diagnosis of primary pulmonary leiomyosarcoma must be made with caution and is justified only after ruling out the possibility of an occult extrapulmonary primary. Clinically and radiographically these lesions present in a fashion similar to bronchogenic carcinoma including male predominance and the propensity to arise near the hilum. However, they tend to affect an age group averaging two decades younger.[15]

Histologically these lesions consist of spindle-shaped cells with pale eosinophilic cytoplasm and large cigar-shaped nuclei. Mitoses are frequent. The cells are generally arranged in intertwining fascicles

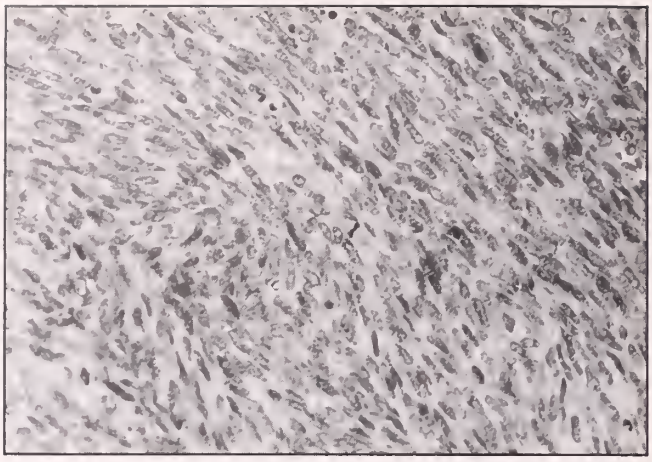

Fig. 5.—Sections of the leiomyosarcoma show whorls and fascicles of oblong cells with frequent mitotic figures. (256x, hematoxylin and eosin).

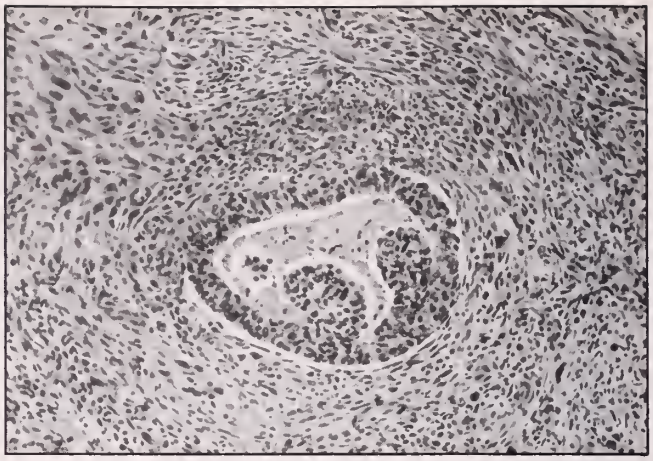

Fig. 6.—Regions of the pulmonary blastoma exhibit both malignant stromal and glandular components. (256x, hematoxylin and eosin)

(Fig. 5). Immunoperoxidase staining for desmin is usually positive. Salient histologic features with prognostic implications are the mitotic rate and the presence of invasion of adjacent structures.[15] Our solitary case of pulmonary leiomyosarcoma occurred in a 65-year-old white male who was being followed with sequelae from a recent head trauma. A routine chest x-ray during that time revealed a right middle lobe mass. The mass was biopsied and a lobectomy was performed. One year later the patient suffered a recurrence and a complete right pneumonectomy was performed. He was treated with radiotherapy and has since been lost to follow-up.

Pulmonary blastoma ● The pulmonary blastoma is a malignant lung tumor which differentiates in such a manner as to produce an appearance of lung during its fetal development. This pattern greatly resembles the malignant stroma of Wilm's tumor. It additionally bears an epithelial component which is usually characterized by the presence of glandular differentiation as well as other regions which are frankly sarcomatous[16,17] (Fig. 6). Several series in the literature bear out the malignant nature of this tumor.[17-19] Diagnosis of pulmonary blastoma requires a thorough ruling out of a variety of metastatic processes including metastatic carcinosarcoma, squamous cell carcinoma with spindle cell component, and teratoma.[16]

Our first case was a 72-year-old white female who presented to her physician with a right lower lobe pneumonia. Chest x-ray revealed a pleural-based mass of the right lower lobe.

The second case involved a 47-year-old white female with a history of allergies. Routine chest x-ray divulged a mass in the apex of the right upper lobe. Both patients were treated with lobectomy and both are currently alive and well without recurrence, case one five years postlobectomy and case two four months postlobectomy.

Conclusion ● Twenty-three cases of primary nonepithelial tumors of the lung encountered in a community hospital over a ten year period have been summarized. This series reflects the potential variety of such tumor types and gives a brief overview of their various modes of presentation and clinical courses. Among the cases, the hamartoma was the single most common diagnostic entity and all 14 of these tumors were treated successfully via surgical excision. Unexpected observations included the high incidence of cigarette smokers among hamartoma patients (12 of 14) and the high coincidence of bronchogenic carcinomas (four of 14).

Of the nine remaining lesions, all were malignant. Their cell types reflected the mixed composition of the pulmonary stroma (lymphoid, fibrous, muscular) and clinical courses exhibited a more varied spectrum of success. Of the malignant lesions, the most common was lymphoma, with several forms of non-Hodgkin's lymphoma, Hodgkin's lymphoma, and lymphomatoid granulomatosis represented.

Although these lesions comprise a minority of primary lung neoplasms, this series of cases and associated literature sampling highlight their repeated occurrence within the pulmonary parenchyma. In light of this, we would underscore that awareness of these entities is desirable from the standpoint of pathologist and clinician alike in the efficient evaluation and accurate diagnosis of pulmonary neoplasia.

References

1. Bateson, E.M.: So-called Hamartoma of Lung — True Neoplasm of Fibrous Connective Tissue of Bronchi, Cancer 6:1458-1467, 1973.
2. Butler, C. and Kleinerman, J. Pulmonary Hamartoma, Arch. Path. 88:584-592, 1969.
3. Spencer, H. Pathology of the Lung, 4th ed., Oxford, Pergamon Press, 1985, p. 1066.
4. Hartman, G.E. and Shochat, S.J. Primary Pulmonary Neoplasms of Childhood, Ann. Thoracic Surg. 36:108-119, 1983.
5. Freeman, C., Berg, J.W., and Cutler, S.J. Occurrence and Prognosis of Extranodal Lymphomas, Cancer 29:252-260, 1972.
6. Koss, M.N., Hochholzer, J., Nichols, P.W., Wehunt, W.D., and Lazarus, A.A.: Primary Non-Hodgkin's Lymphoma and Pseudolymphoma of Lung, Human Path. 14:1024-1038, 1983.

7. L'Hoste, R.J., Filippa, D.A.; Lieberman, P.H., and Bretsky, S.: Primary Pulmonary Lymphomas, Cancer 54:1397-1406, 1984
8. Peterson, H., Snider, H.L., Yam, L.T., Bowlds, C.E.; Arnn, E.H., and Li, C.Y.: Primary Pulmonary Lymphoma, Cancer 56:805-813, 1985.
9. Whitcomb, M.E., Schwartz, M.L., Keller, A.R., Flannery, E.P., and Blom, J.: Hodgkin's Disease of Lung, Am. Rev. Res. Dis. 106:79-85, 1972.
10. Kern, W.H., Crepau, A.G., and Jones, J.C.: Primary Hodgkin's Disease of Lung, Cancer 14:1151-1165, 1961
11. Colby, T.V. and Carrington, C.B.: Pulmonary Lymphomas Simulating Lymphomatoid Granulomatosis, Am. J. Surg. Path. 6:19-32, 1982.
12. Weis, J.W., Winter, M.W., Phyliky, R.L., and Banks, P.M.: Peripheral T Cell Lymphomas: Histologic, Immunohistologic, and Clinical Characterization, Mayo Clinic Proc. 61:411-426, 1986
13. Silverman, J.F. and Coalson, J.J.: Primary Malignant Myxoid Fibrous Histiocytoma of Lung, Arch. Path. Lab. Med. 108:49-54, 1984
14. Tapia R.H., Taylor F.M., and White V.A.: ASCP Check Sample 9:1-4, 1985
15. Wick, M.R.; Schiethauer, B.W., Piehler, J.M. and Pairolero, P.C.: Primary Pulmonary Leiomyosarcomas, Arch. Path. Lab. Med. 106:510-514, 1982.
16. Francis, D. and Jacobsen, M.: Pulmonary Blastoma, Cur. Topics Path. 73:265-294, 1983
17. Nazari, A.; Amir-Mokri, E., Sarram, A., and Yaghmai, I.: Pulmonary Blastoma, Chest 60:187-189, 1971.
18. Gabriel, J.B., Ibanez, I., Kondlapoodi, P., Chauhan, P.M., and Hagstrom, J.W.: Carcinosarcoma of Lung with Spindle Cell Epithelial Component, J. Surg. Oncology 25:116-118, 1984
19. Ohtomo, K., Araki, T., Yashiro, N., and Ito, M.: Pulmonary Blastoma in Children, Radiology 147:101-104, 1983.

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Screening Newborn Infants for Sickle Hemoglobin

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ABSTRACT: During fiscal year 1988-1989, blood specimens of all children born in Florida will be tested for abnormal hemoglobins through the metabolic screening program administered by Children's Medical Services in the Department of Health and Rehabilitative Services. This will identify those with sickle cell anemia, hemoglobin SC disease, and other hemoglobinopathies and result in provision of health care to avoid or minimize associated complications. The infant's physician will be notified when the result indicates a major hemoglobinopathy so that confirmatory testing and counseling can be done. Infants with no known physician will have further testing by the Childrens Medical Services Hematology Centers. When an abnormal test is confirmed, the child can be provided with preventive health care and the family with appropriate counseling.

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During fiscal year 1988-1989, blood specimens from all infants born in Florida will be screened for the presence of abnormal hemoglobin. This will allow detection of sickle cell anemia, hemoglobin SC disease, S and thalassemia (S-beta zero thalassemia), or other abnormal hemoglobins during the first month of life. In addition, babies with sickle trait, hemoglobin C trait, alpha thalassemia or beta thalassemia major will be identified.

Several reasons justify establishment of this program. Serious, even life-threatening medical problems are frequently encountered by young children who have sickle cell disease. In fact, the first identifiable medical problem might be death from overwhelming pneumococcal infection. Since penicillin prophylaxis can significantly reduce the risk of these infections, waiting for clinical signs to make the diagnosis is invalidated. The advent of accurate, cost-effective screening tests has led to establishment of statewide programs in New York,[1] Texas, North Carolina and Maryland.

Early identification allows careful medical supervision which should minimize the complications these patients encounter. Preventive health care can be provided using principles valuable for hematologically normal children. In addition, the incidence of serious pneumococcal infections can be decreased by prescribing prophylactic penicillin and immunization with pneumococcal polysaccharide antigen.

Background ● At birth, the infant's hemoglobin is composed primarily of hemoglobin F (fetal hemoglobin). Hemoglobin A production begins during the third trimester and is essentially the only other hemoglobin normally present at that time. During the first two years of life the proportions of these hemoglobins change such that by age two hemoglobin F comprises 2% of the total. Hemoglobin A_2 is a minor hemoglobin normally present in concentra-

Table 1.—Incidence Figures for Several Hemoglobin Abnormalities Encountered as Part of the Statewide Screening Program.*

PHENOTYPE	INCIDENCE	NEWBORN SCREENING RESULT	BLACK AMERICANS			WHITE AMERICANS		
			NEW YORK	MIAMI	L.A.	NEW YORK	MIAMI	L.A.
Sickle Cell Anemia	18**	FS	22	30	39	1	0	0
Sickle beta-zero thalassemia	2 (9)							
Sickle-HPFH	0.4 (14)							
Hemoglobin SC Disease	5**	FSC	12	17	12	1	5	0
Homozygous Hemoglobin C	1.4**	FC	2	2	5	0	0	0
Beta thalassemia	N.A.	F	—	—	—	—	—	—
Hereditary Peristence of Fetal Hemoglobin	—							
Sickle beta-plus thalassemia	3.3 (9)	FSA	—	—	—	—	—	—
Sickle trait	860 (3)	FAS	698	684	793	128	248	49
Hemoglobin C trait	240 (3)	FAC	210	310	208	15	59	7
Alpha thalassemia	3000 (10)	BARTS	—	—	—	—	—	—

*Values are expressed as the number of cases per 10,000 births and were extrapolated from data contained in the references cited. No figures are available on the incidence of homozygous beta thalassemia, but its occurrence would be expected to be confined primarily to populations originating from the Mediterranean or Orient.
**The value was calculated from the rates listed for the heterozygous states.

tions no greater than 4%. The concentrations of either hemoglobin F or A_2 may be elevated in beta-thalassemia which is characterized by deficient hemoglobin A production.

Hemoglobin S is an abnormal hemoglobin that results from a single amino acid substitution at position 6 on the beta globin chain. When deoxygenated, hemoglobin S changes from a solution to a semisolid gel which distorts the red cell membrane causing a change from the normal discoid to a sickle shape.[2]

Hemoglobin C results from a different amino acid substitution at position 6 of the beta globin chain. Pure solutions change little in response to the degree of deoxygenation encountered in vivo. However when mixtures of hemoglobins S and C are deoxygenated they are only slightly less likely to form aggregates than pure solutions of hemoglobin S.

The prevalence of the genes for hemoglobins S and C are reported to be 8.6% and 2.4% in the American Black population.[3] These rates can be used to calculate an expected birth rate for sickle cell anemia of 0.18% or one case per 556 births.[4] Hemoglobin SC disease which is the double heterozygous state for the two hemoglobins should occur in 0.05% or one case per 2,000. Using current birth rates for Florida, 84 Black infants are born with the former and 23 with the latter disorder each year. Additionally there are 4,025 heterozygotes for hemoglobins A and S (sickle trait) and 1,023 heterozygotes for hemoglobins A and C (C trait) born each year.

Table 1 lists the rates at which the various sickle hemoglobinopathies are said to occur in American Black infants. It also lists the actual rates reported from the screening program in New York[1] and the limited programs in Los Angeles[6] and Miami.[7] These are valuable since in addition to demonstrating a reasonable agreement with the accepted rates for Black infants they include the results from white infants screened.

Although these disorders occur primarily in Blacks, they are also found in other racial and ethnic groups. Areas having nonblack populations with high hemoglobin S prevalences include Southern Italy, Northern Greece, Southern Turkey, India, the eastern province of Saudi Arabia and Colombia.[5] It is apparent from data in the table that hemoglobin S and C is found in a significant percentage of white infants in this country as well.

The white populations tested in the reports previously cited included a significant percentage of Hispanic infants. In Los Angeles, these infants were

of Mexican origin and had rates of hemoglobins S and C similar to the white infants tested at that hospital.

In Miami, Hispanic infants comprised 71% of the white babies born. Data available on the mother's place of birth indicated the majority originated in Cuba, Puerto Rico, Honduras, Nicaragua, Colombia with a smaller representation from other south and central American countries. The rates of hemoglobins S and C were similar for each subgroup but considerably higher than those reported from Los Angeles.

In New York no information was provided to describe what proportion of the white population was made up of Hispanic infants. The authors state that the majority of white infants who had sickle cell anemia, hemoglobin SC disease or the respective traits were Hispanic. The national origins of the Hispanic infants in that study were not further characterized.

From these data it can be surmised that white infants heterozygous for hemoglobins S and C will be found with some frequency in Florida. In addition, we can expect that some will have sickle cell anemia or hemoglobin SC disease.

Disease description ● Sickle cell disease is a general designation for several disorders having in common a predominance of hemoglobin S as the basis for clinical abnormalities. Their considerable variability requires that the specific diagnosis be made whenever posssible to allow an intelligent approach to prognosis and treatment. The clinical manifestations most likely to be encountered in these disorders during the first several years of life are listed in Table 2 according to the hemoglobin electrophoresis result reported from the state laboratory. More precise diagnoses are difficult in the first year unless family studies can be done. The clinical approach in such situations requires management for the most severe of the diagnostic possibilities until the situation can be clarified.

Sickle cell anemia results when a child inherits the gene causing hemoglobin S production from each parent. This hemoglobin is predominant in the red blood cells of such children. Cells that have changed shape become much less pliable and are unable to traverse the microvasculature, thus interfering with circulation and resulting in the numerous, characteristic abnormalities. Affected children are very susceptible to overwhelming infections with *Streptococcus pneumoniae*. They may also have splenic sequestration, the sudden entrapment of a large volume of blood by the dysfunctional spleen. They have a chronic, hemolytic anemia with an average red blood cell lifespan of ten days (range 2-21) compared to the normal survival time of 120 days.[8] Finally, they may have an aplastic crisis which is an acute worsening of the anemia that results from a viral induced temporary cessation of red cell production.

Hemoglobin SC disease occurs when a child inherits the gene for hemoglobin S from one parent and hemoglobin C from the other. This mixture of abnormal hemoglobins can become distorted at low oxygen saturations and cause circulatory interference and hemolysis. However, they are less likely to do so than cells containing only hemoglobin S so fewer clinical problems are encountered, at least during childhood.

Several less common variations may be encountered. Sickle-thalassemia occurs when the gene for hemoglobin S is inherited from one parent and that for beta thalassemia from the other.

If the thalassemia gene results in no beta globin chain and consequently no hemoglobin A production, it is termed S-beta zero thalassemia. This disorder is characterized in older children and adults by the presence of hemoglobins S and F with a hemoglobin A_2 concentration above the normal 4%. It is estimated to occur in one in 5,000 births in the Black population in North America.[9] Since hemoglobin F lessens the tendency for hemoglobin S to change from liquid to gel when deoxygenated, clinical severity may be lessened if the patient produces it in high concentrations.

If the thalassemia gene allows the production of some beta globin, some hemoglobin A will be present. Usually such patients have approximately 70% hemoglobin S and 30% hemoglobin A. This disorder is called S-beta plus thalassemia and those affected are subject to some of the complications encountered by those homozygous for hemoglobin S. Its incidence in Jamaica was shown to be one in 3,000 births.[9] Problems are milder and less frequent and are said to be similar to those encountered by children with hemoglobin SC disease.

Sickle trait occurs when an individual inherits a gene for hemoglobin S from one parent and one for hemoglobin A from the other. Likewise, C trait results from the inheritance of the genes for hemoglobin A and C. Sickle and C traits are not diseases. The former has been associated with occasional health problems, the latter has not. Their main importance relates to the major hemoglobinopathies that can result when affected couples have children.

Alpha thalassemia is the result of decreased production of alpha globin chains by virtue of deletion of responsible genes. It occurs in approximately 30% of black Americans[10] and can result in a mild microcytic, hypochromic anemia of no clinical significance. In fact, it is believed to have some beneficial effect on the clinical manifestations of sickle cell anemia when the two conditions occur together.[11] Its diagnosis in older subjects is difficult, requiring DNA techniques not available in clinical laboratories. At birth, the diagnosis can be suspected by identifying hemoglobin Barts which is a tetramer of gamma globin chains that is formed as a result of insufficient production of alpha globin chains.

Laboratory results ● Hemoglobin electrophoresis will be performed on blood collected on filter paper from

Table 2.—Comparison Between Hemoglobin Electrophoresis Result Obtained at Time of Newborn Screening, Possible Diagnoses and Ultimate Hemoglobin Electrophoresis Results Expected After One Year of Age.*

Screening Result	Presumptive Diagnosis	Ultimate Hemoglobin Electrophoresis			Anemia	Pain	Infection	Splenic Sequestration	Aplastic Crisis
		Major Hbg	Hbg F	Hbg A_2	Occurrence/Severity		Risk		
FS	Sickle Cell Anemia	S	<20%	<4%	frequent/ severe	frequent/ severe	high	high	high
	Sickle beta-zero Thalassemia	S	+/−20%	>4%	frequent/ moderate	frequent/ severe	high	high	high
	Sickle-HPFH	S	>20%	<4%	infrequent/ mild	infrequent/ mild	low	high	high
FSC	Hemoglobin SC Disease	SC	<20%	NA	frequent/ mild	infrequent/ moderate	high during 1st 2 years	low	low
FC	Homozygous Hemoglobin C	C	<20%	NA	none	none	none	none	none
F	Beta thalassemia	F	>20%	>4%	frequent/ severe	none	none	none	none
	Hereditary Persistence of Fetal Hemoglobin	F	>20%	<4%	infrequent/ mild	none	none	none	none
FSA	Sickle beta-plus Thalassemia	SA	+/−20%	<4%	infrequent/ mild	infrequent/ mild	low	high	low
FAS	Sickle trait	AS	<20%	<4%	none	none	none	none	none
FAC	Hemoglobin C trait	AC	<20%	NA	none	none	none	none	none
BARTS	Alpha thalassemia	Clinical manifestations will be as listed for the hemoglobin phenotype above. A mild microcytic anemia will be found in addition to the abnormalities listed.							

*The concentration of hemoglobin A_2 cannot be determined in the presence of hemoglobin C since their electrophoretic mobility is identical. A general characterization of the clinical manifestations of the various hematologic diagnoses is also provided.

each newborn as part of the Metabolic Screening Program.[12] The specific electrophoretic method used will be isoelectric focusing, a technique that allows very clear demonstration and identification of hemoglobin types.[13] The results that will be reported are summarized in Table 1. At the time of birth, normal children will have hemoglobins F and A. Those who have hemoglobins F and S will be presumptively diagnosed as having sickle cell anemia. It will be impossible to distinguish this disorder from the milder subtypes, S-beta O thalassemia and S-HPFH (hereditary persistence of fetal hemoglobin) without further hematologic tests and family studies. Until a specific diagnosis can be made, the safest practice will be to treat all such children as if they had sickle cell anemia. Specimens found to have hemoglobins F, S and C are diagnostic for hemoglobin SC disease.

Infants whose specimens contain hemoglobins F, A and S (FAS) or F, A and C (FAC) are presumed to have sickle or hemoglobin C trait. However, the finding of those three bands with hemoglobins S or C concentration greater than hemoglobin A indicates the child has S or C-beta plus thalassemia. Since the laboratory reports hemoglobin bands in the order of concentration, such results will read FSA or FCA. Family studies will be needed to confirm these diagnoses.

Hemoglobin Barts can occur in the presence of any of these diagnoses. That is to say, alpha thalassemia can occur as an isolated diagnosis or in combination with the traits or major hemoglobinopathies.

Finally, if only hemoglobin F is found on a newborn specimen, the child may have homozygous beta thalassemia. The potential severity of this disorder is such that the diagnosis should be made at the earliest possible date so treatment can be started.

Program description ● A description of the design of the Hemoglobinopathy Screening Program follows. It outlines the response that will be generated for each of the possible laboratory results.

If the electrophoresis reveals hemoglobins FA, FAS or FAC, the report will be mailed to the facility where the specimen originated with a copy to the infant's physician as listed on the request form. The parents of

Table 3.—Regional Childrens Medical Services Hematology Centers, Responsible Pediatric Hematologists and Telephone Numbers.

CENTER	DAYTIME NUMBER	AFTER HOURS NUMBER
University of Florida Gainesville Samuel Gross, M.D. William Cassano, M.D. John Graham-Pole, M.D. Paulette Mehta, M.D.	(904) 392-5619	(904) 392-3331
University of Miami Miami Charles Pegelow, M.D. Joanna Davis, M.D. Susan Light, M.D. Stuart Toledano, M.D.	(305) 549-7752	(305) 549-7320
University of South Florida Tampa Janifer M. Judisch, M.D. Eva Hvizsdala, M.D. Jaime Estrada, M.D.	(813) 972-8430	(813) 972-8430
University Hospital of Jacksonville Jacksonville Paul Pitel, M.D.	(904) 632-3902	(904) 350-6899
All Children's Hospital St. Petersburg Jerry Barbosa, M.D. Carol Lehan, M.D.	(813) 892-4176	(813) 898-7451
Orlando Regional Medical Center Orlando Vincent Giusti, M.D. Kjell Kock, M.D.	(305) 237-6320	(305) 841-7920
Sacred Heart Hospital Pensacola Thomas G. Jenkins, M.D. Nilka Barrios, M.D.	(904) 478-1100	(904) 478-1100

infants with FAS and FAC will receive a letter informing them of the result and advising them to contact their physician, health department or local Sickle Cell Foundation for further testing and counseling.

If the results show hemoglobins FS, FSC, FSA, FCA, FC or F, the Childrens Medical Services Program Office will immediately contact the infant's physician who will be asked if he or she wishes to take responsibility for confirmatory testing and family counseling. If so, a fact sheet designed to facilitate counseling and brochures for parents will be mailed to the physician. Finally, suggested treatment strategies will be provided for each child.

If the physician does not wish to provide counseling, the local Children's Medical Services office will contact the family and arrange a clinic visit. A blood specimen will be obtained and sent to a Hematology Center. The results will be reported to the infant's physician, local CMS office and the Program Office. At this point, counseling and preventive health care can begin. The Program Office will track children found to have major hemoglobinopathies to ensure that they are contacted and their families counseled. Consultation pertaining to diagnosis, counseling and medical management is available from the Hematology Centers (Table 3).

This program represents a major step forward in the provision of medical care for children affected with these hematologic disorders. Its design should result in a significant decrease in their morbidity and mortality.

References

1. Grover, R., Shahidi S., Fisher, B., et al: Current Sickle Cell Screening Program for

Newborns in New York City, 1979-1980, Am. J. Pub. Health 73:249-252, 1983.
2. Platt, O.S. and Nathan D.G : Sickle Cell Disease. In Nathan, D.G. and Oski, F.A eds. Hematology of Infancy and Childhood. Philadelphia: W.B. Saunders, 3rd ed., 1987, pp. 655-698.
3. Motulsky, A.G.: Frequency of Sickling Disorders in U.S. Blacks, N. Engl. J. Med. 288:31-33, 1973.
4 Fleming, A F· Sickle Cell Trait, Genetic Counselling. In Fleming, A.F., ed., Sickle Cell Disease: Handbook for General Clinician, Edinburgh: Churchill Livingston, 1982, pp. 22-32.
5. Serjeant, G.R.; Geographical Distribution of Sickling. In Serjeant, G.R., ed., The Clinical Features of Sickle Cell Disease, New York, American Elsevier Publishing Inc., 1974, pp. 28-43.
6. Ewing, N., Powars, D.; Hilburn, J., and Schroeder, W.A.: Newborn Diagnosis of Abnormal Hemoglobins from Large Municipal Hospital in Los Angeles, Am. J. Pub. Health 71:629-631, 1981.
7. Pegelow, C. and Mack A · Prevalence of Hemoglobins S and C in Hispanic and Haitian Children, Clin. Rex 35:64a, 1987.
8. Serjeant, G.R.: In Sickle Cell Disease, Oxford, Oxford University Press, 1985, pp. 92.
9. Ibid, p. 306.
10. Dozy, A.M., Kan, Y.W., Embury, S H., et al: Alpha Globin Gene Organization in Blacks Precludes the Severe Form of Alpha Thalassemia, Nature 280:605-607, 1979.
11 Steinberg, M.H., Rosenstock, W., et al: Effects of Thalassemia and Microcytosis on Hematological and Vaso-occlusive Severity of Sickle Cell Anemia, Blood 63:1353-1360, 1984
12. Stempfel, R.S.: Florida's Infant Screening Program for Metabolic Disease, J. Fla. Med. Assoc. 70:779-787, 1983.
13. Galacteros, F., et al: Cord Screening for Hemoglobin Abnormalities by Thin Layer Isoelectric Focusing, Blood 56:1068-1071, 1980.
14. Serjeant GR. In Sickle Cell Disease. Oxford: Oxford University Press. 1985:326.

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Refractory Edema: Evolving Status of Albumin and Furosemide

Stephen Sandroni, M.D.

***ABSTRACT:** Research suggests a renewed role for albumin as a transport vehicle for furosemide in the management of edematous patients with low serum albumin levels. Three cases are presented to illustrate the potential usefulness of two methods of albumin-furosemide infusion in the outpatient therapy of refractory edema.*

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Edema in hypoalbuminemia can pose severe management problems. Traditional therapies including sodium and fluid restriction, diuretics, and bed rest may be ineffective or too slow to be clinically useful. When edematous patients decompensate, re-equilibration can be time-consuming, morbid, and expensive. Recent advances offer new insight into mechanisms of diuretic resistance and the hope of quicker and more effective pharmacologic resolution of refractory edema. The three cases presented illustrate the potential adjunctive role of albumin in this setting.

In hypoalbuminemic refractory edema it has been generally accepted that albumin infusion can help to mobilize fluid by increasing the oncotic pressure of the intravascular space. While albumin can "prime the pump" it is expensive and short-lived therapy.[1] Inoue et al working with analbuminemic rats and hypoalbuminemic patients suggest that albumin may have a different role in management of refractory edema.[2] Furosemide, a potent diuretic, like other organic acids, binds strongly to albumin.[3] Thus it is actively transported from the blood to the proximal tubule at an organic acid transport site.[4]

Analbuminemic rats and hypoalbuminemic humans demonstrate resistance to furosemide. Experiments with rats suggested that there was impaired accumulation of furosemide in the kidneys. Injection of furosemide bound to small amounts of albumin resulted in an increase in the urine and markedly increased diuresis. Subsequent trials among patients resulted in increased urine output in 14 of 16. The small amount of albumin used in these studies would not have altered plasma oncotic pressure and, instead, supports a role for albumin as a "vehicle" for furosemide transport to the kidneys.

We do not have access to a furosemide-albumin complex but reasoned that albumin infusion followed

by furosemide might accomplish the same goal, if less efficiently.

Case 1 ● A 70-year-old woman was referred to the renal clinic in 1986. She had nephrotic range proteinuria during a previous hospitalization for congestive heart failure.

Serial 24 hour urine specimens revealed nephrotic range proteinuria and the physical examination peripheral pitting edema. A kidney biopsy showed a mild mesangial proliferative lesion. Prednisone therapy markedly worsened the edema without any appreciable impact on the proteinuria. It was discontinued.

Four months later she was admitted to the hospital with severe bilateral pitting edema, pleural effusions, and symptoms of congestive failure. She weighed 167 pounds. Bed rest, fluid restriction, increased diuretics, and low sodium diet resulted in a nine pound weight loss and only modest symptomatic improvement. Over a 12 day period, edema and effusions persisted. Her serum creatinine was 2.0 mg/dl.

When seen as an outpatient, the albumin was 2.1 gm/dl and there were symptoms of congestive heart failure. She was given 50 gm of albumin followed within minutes by 120 mg of furosemide, and discharged home to continue maintenance diuretic therapy, which consisted of 160 mg daily of furosemide and 10 mg daily of metolazone. When seen again three days later she had lost eight pounds, with improved symptoms. Fifty gm of albumin was again administered intravenously followed by 120 mg of furosemide. Continuing her usual diuretics she returned four days later having lost seven pounds. Fifty gm of intravenous albumin were given, followed by 80 mg of furosemide. This resulted in a further four pound weight loss, a total of 21 pounds over a 13 day period. She has been edema free and asymptomatic on reduced maintenance diuretic therapy since that time. Her current creatinine is 1.7 mg/dl.

As shown in Table 1, the cost of outpatient management was not negligible but much less than inpatient therapy.

Table 1. — Hypoalbuminemic Refractory Edema, Inpatient vs. Outpatient Management.*

	Cost	Weight Loss
12 Day Admission	$6,100.00	9 lbs.
Outpatient Therapy	$ 426.00	21 lbs.
Difference	$5,674.00	

* Including physician fees and medication administration

Case 2 ● Severe nephrotic syndrome secondary to diabetic nephropathy developed in a 26-year-old woman. She presented in December 1987 with serum creatinine of 2.4 mg/dl and serum albumin of 2.0 gm/dl. In addition to severe bilateral pitting edema of both legs she had periorbital edema severe enough to limit her field of vision. Previous diuretic treatment consisted of furosemide alone (in doses up to 320 mg/day), furosemide plus metolazone, and bumetanide alone. Intravenous furosemide in doses up to 200 mg was ineffective on an outpatient basis. She was then given 25 gm of intravenous albumin followed by 100 mg of intravenous furosemide. This initiated brisk diuresis which was sustained over the next four days at home where she continued maintenance oral furosemide. She lost nine pounds over this period. Three more albumin-furosemide infusions at weekly intervals resulted in the loss of another 15 pounds. The serum creatinine remained stable during this time. She was maintained on oral furosemide for several months, but subsequently the creatinine rose progressively and she became more edematous. Another infusion helped to control the edema so that access surgery for dialysis could be performed.

Case 3 ● A 21-year-old woman presented in April 1988 with nephrotic syndrome and an active urinary sediment. The serum creatinine was 1.9 mg/dl; it had been 0.7 mg/dl six months earlier. The serum albumin was 0.9 gm/dl, and she documented a recent 22 pound weight gain with severe edema. Bed rest and intravenous furosemide resulted in a limited three pound diuresis. Edematous areas included her back, thus increasing the risk of a planned kidney biopsy. Furosemide 100 mg was injected into the albumin bottle, the furosemide-albumin mixture was shaken and infused into the patient. A diuresis of nine pounds occurred over the next 24 hours. Further diuresis was obtained with a furosemide-albumin mixture of 50 mg in 25 gm. The edema of her back completely resolved, allowing safer performance of the biopsy.

Discussion ● Results obtained in these three patients are consistent with published experimental and clinical data and support the concept that combined use of albumin and furosemide can significantly increase diuresis in cases of refractory edema.

The doses of albumin and furosemide were empirically determined and may not be optimal. These patients improved clinically and demonstrated no ill effects from diuresis; however the rates of fluid removal were quite high and cannot be presumed to be safe for other patients. Additional study will be necessary to determine both the optimal doses and best route of administration (sequential or combined infusion).

Refractory edema remains a difficult clinical challenge. Modest alterations in the use of clinically

available agents can provide significant improvements in efficacy and reduced duration of therapy. These factors can lead to substantial savings, and such savings can be used to justify further investigations in this area.

References

1. Hutt, M. and Glassock, R.: Proteinuria and Nephrotic Syndrome, in Renal and Electrolyte Disorders, Second Edition, Little, S.R. (ed.), Brown, 1980, p. 517.
2. Inoue, M; Okajima, K.; Itoh, K., et al: Mechanism of Furosemide Resistance in Analbuminemic Rats and Hypoalbminemic Patients, Kidney International 32:198-203, 1987.
3. Andreason, F.: Determination of Furosemide in Blood Plasma and Its Binding to Proteins in Normal Plasma and in Plasma from Patients with Acute Renal Failure, Acta Pharmacol Toxicol 32:417-429, 1973.
4. Brater, C.: Resistance to Diuretics, Drugs 22:477-494, 1981

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Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract* Bone and Joint* Skin/Skin Structure*	Mild/Moderate	500 mg *B.I.D.*
	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
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BRIEF SUMMARY
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INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

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Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes.*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General:

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions:

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients:

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility:

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C:

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers:

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of th and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision sho be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to t mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (S WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possi related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous syst (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiti (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical quinolones are italicized.

GASTROINTESTINAL: *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforatio gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM: *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucin tions, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakne malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY: *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chill angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigment tion, erythema nodosum

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception, overbrightness of lighti decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL: *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL: *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleedin vaginitis, acidosis

CARDIOVASCULAR: palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pecton myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY: epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospas pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug wa discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged b investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction wi ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to dru relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4% serum bilirubin (0.3%).

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated bloo platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should b emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportiv treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if rena function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients wit complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treate with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 1 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AN ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and i Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

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An Epidemic Affliction of Contemporary Physicians

H.J. Roberts, M.D.

May 29, 1987, a memorable milestone, was my 63rd birthday and the date of the 40th reunion of the 1947 Tufts Medical School class. But other encounters that day proved more sobering.

Carol and I flew to Boston, which preempted attending a formal dinner of the University of Florida's President's Council that evening. I had been designated a "distinguished" member of the Council but my class reunion held a higher emotional priority.

Once again I felt the awe and anxious expectation that had preceded class reunions ten and five years earlier; awe out of gratitude that my classmates and I had lived to enjoy this gala occasion, anxiety over personal or professional tragedies that had befallen our peers since we last met.

The Author
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The large turnout of the "40th" impressed every one, most of all the three dozen of our vintage who attended. I was pleased that the majority of these seasoned physicians and respected citizens looked so well.

We were quickly updated. Several classmates either were retired or retreaded. News about the death of Judy, Pete's charming wife with whom we had celebrated these q. five year reunions over the past quarter century, came as a shock.

Pessimistic overtones ● Carol felt a bit disturbed as she read the booklet of personal resumes written by members of my class, most of whom still practiced in Massachusetts. Two themes kept reappearing under "Remarks": the deteriorating professional and economic climate for doctors in the Bay State, and the ominous implications of accelerating changes in American medicine. Rather than focusing upon their deserved "prime," a number of these dedicated physicians chose to express disillusionment and their intention of leaving medicine. Such laments reminded her of the tragedy of seasoned teachers opting to give up their profession rather than endure the aggregated hostility of students, parents, administrators and politicians.

These pessimistic overtones puzzled Carol. The "Remarks" feature was clearly intended to convey four decades of mellowed insights. As she prepared for the first event, Carol assumed that her inferences had been overly critical. But the same issues repeatedly insinuated themselves during *every* discussion at the reception and dinner. Some examples:

- A compassionate obstetrician-gynecologist had applied for licensure in New Hampshire "to get away from this madness."
- A neurosurgeon now practiced only neurology to

avoid confiscatory malpractice insurance payments, and to minimize involvement in the outrageous epidemic of lawsuits plaguing his specialty.
- Two classmates anguished over accusations of "abandoment" after they had sent letters to patients indicating either a change in practice or pending retirement.
- Several colleagues poignantly asked almost the identical question: "Do we *really* deserve this after having devoted most of our lives trying to be good doctors?"

My classmates raised additional issues that were actively troubling most of my colleagues in Florida. They included:

- Erosion of the coveted private relationship between physicians and their patients by "third parties."
- Bureaucratic harassment of primary care physicians by Medicare, Social Security, Medicaid, and insurance or HMO carriers, especially requests for the justification of emergency services necessitating considerable time and effort — at the risk of stiff penalties for services deemed to be "unnecessary."
- The emphasis upon "defensive medicine" for protection against greedy patients and greedy attorneys in a litigious society wherein physicians are regarded as the "prized lottery pelt," even when care was rendered *free*. For instance, six of the 17 awards made by Palm Beach County juries since 1982 exceeded $17 million. (The telephone-number fees of successful plaintiff attorneys averaged $447,080.)

  As a result, several local hospital administrators proclaimed Palm Beach County the most hostile environment for medical practice in the United States. (Concomitantly, it became the most fertile area for recruiting quality physicians.) One of my major hospitals lost its orthopedic staff, and neurosurgeons abandoned the other. In the wake of these events, at least nine colleagues whom I respected decided to retire prematurely.
- The need for "providers" to "network" in a competitive "health industry" if they were to make ends meet.
- The dehumanization of physicians resulting from administrator demands and an increasing reliance upon high-tech equipment.
- The acceleration of bureaucratic harassment. For example, a Florida law, the first of its kind in the nation, mandated that "dispensing practitioners" complete six hours of formal education in pharmacy every year for relicensure or "be subject to suspension or revocation."
- The ongoing confrontation with complex ethical matters such as "living wills," determination of "brain death," and caring for the poor, the elderly and the traumatized when state and federal agencies refuse or cannot afford the needed facilities and funds. The hospital with the largest emergency room load previously serving indigent patients in Palm Beach County has halted walk-in patients rather than risk bankruptcy.
- Loss of the time-honored appeal for teaching due to excessive physical demands, the arrogance of support staffs, and increased medicolegal exposure.

Another prime etiology for this malignant attitude surfaced: Massachusetts' requirement of acceptance of Medicare and Medicaid fee schedules for relicensure. Many young physicians simply cannot earn a living there, especially as their oft-huge economic debts became due from loans taken during medical school and residency training. They are forced to emigrate, join the military, or involve themselves in business careers.

Threatened pride ● I found myself querying classmates closely to rule out group paranoia. It failed to materialize. At this stage of their careers, few were interested in relentlessly pursuing the buck. The real problem seemed threatened pride and self-esteem among individuals who had forged enviable reputations in a "free enterprise system" while simultaneously responding to a high professional calling.

Another domino effect was encountered in this milieu of discontent. My classmates and their wives (many of whom were former nurses) *actively* discouraged their children from embarking upon medical careers. They pointed to annual *starting* salaries as high as $70,000 that some graduates of law schools now command — sans the years of aggravation, physical exhaustion and relative poverty inflicted by residency training.

As the parents of two physician-sons, these bitter remarks hit us between the eyes. We recalled the taunts leveled by son #4 (an M.B.A. graduate from Wharton), and son #5 (an emerging developer-tycoon) at their still-struggling older brothers. In point of fact, I already had come to grips with this issue by refusing to insist that either son enter my established practice, lest they later curse the good intentions of their presumed role model.

Dean Henry Banks reinforced the poignancy of this matter by noting the decreased numbers of applicants to United States medical schools, and the escalating tuitions (then $17,000 a year at Tufts). Some medical schools even have been forced to solicit students and to waive longstanding academic requirements.

Carol pondered these ongoings from her unique perspective as a physician's wife, mother of two doctors, and a seasoned politician. Being chairman of the Commission of Palm Beach County (population nearly 800,000) after serving as Mayor of West Palm Beach, she headed the most rapidly developing county in the United States. In fact, she had been twisting arms in Tallahassee about tort reform relative to emergency room care, the urgent need for one or

several trauma centers in the county, and Florida's malpractice crisis several weeks before my class reunion. The latter issue had assumed monstrous proportions after the two largest underwriters announced they would be pulling out of Florida because their demands for extortional rates had not been approved. Most orthopedic surgeons, obstetricians and neurosurgeons at Palm Beach County's major hospitals then either resigned or asked for a leave of absence due to legitimate fears of being wiped out by a single large claim.

Classmates intuitively began querying "My Favorite Politician." Their questions escalated when they learned that she knew Governor Mike Dukakis and his wife personally and had mutual political friends.

At first, Carol was reluctant to discuss these thorny matters. She had come to enjoy a class reunion, not get involved in heated debates, but the guys persisted. Carol then delicately pointed out that most doctors are naive about practical politics, especially when they act as individuals. To soothe feelings, however, she crystallized the absurdity of some expressed anxieties, e.g., it isn't "abandonment" when physicians who cannot get insurance or relicensure decide to revamp or close their practices and formally notify patients of these changes. As we left dinner, I thought, "It's a strange twist. As the youngest member of our class, these fellows used to kid me mercilessly. And now, they're begging for a Dutch Aunt lecture from *my* wife!"

Glooming of medicine ● Over the ensuing year, I reflected on this nationwide glooming of American medicine. Seeking some term that also encompassed my reaction to these encounters, I decided upon "the 40-63-1988 syndrome."

As the medical profession and scientific community doubt their ability to control AIDS, physicians must cope with an equally virulent emotional virus: the 40-63-1988 syndrome. Others have made tangential reference to this phenomenon. Dr. H. Steven Moffic entitled an article, "After Fifteen Years, What Does M.D. *Really* Stand For?" (*The Pharos* Summer 1987, pp. 12-14). A class leader asked on the occasion of his Yale reunion, "Was it all worth it?"

Meaningful solutions to these problems will not come unilaterally from the medical profession. But they require the input of these "7 Cs" by doctors: conviction, commitment, cooperation, consolidation, communication, constructive action, and courage.

Conversely, the failure of physicians to address such extraordinary challenges fosters a scenario I prayed would never happen. It was encapsuled in the title of an article I wrote a quarter century ago, "The Brinkmanship of Socialized Medicine: A Physician Speaks Out" (*Medical Times* 91:335-352, April 1983.) Regretfully, two predictions already proved on target.

- "Conscientious medical care on a private basis by physicians who are doing their utmost to keep up with medical progress and to render personal medical service involving the constant exercise of medical judgment will largely cease to exist."
- "Medicine will no longer be an attractive profession to the most promising young people."

National health care is currently being championed by some politicians and union leaders for self-serving goals. If approved by Congress, the public will have to accept the consequences of having killed the goose that laid the golden egg of American medicine, once respected as the world's best. This includes a medical bureaucracy that functions from 9 a.m. to 4 p.m. on weekdays, excluding a dozen national holidays. Citizens also are likely to rub their eyes in disbelief at the enormous rise in taxes for such health care costs, however limited and mediocre.

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Editor — **Jacques R. Caldwell, M.D.**

The 1988 Elections

A View from the Perch of a Florida Physician

The political ardor of most physicians is tepid, at best. However, the 1988 political season is clambering its way to the November 8th summit and the outcomes of the current elections present more risk to the practice of medicine than most of those in the past. Some examination of the candidates' views on topics that affect the future of medical care is appropriate. Several health issues have been projected for the national presidential race. AIDS testing, federal support of abortion, long-term care for the elderly, the prospect of a national health insurance program and the financing of the Medicare-Medicaid programs. These have been succinctly and articulately summarized by Russell Jackson in a recent issue of FMA Today.[1] However, the paramount but unstated central issue on health care is that of control of the medical care system. Are the traditional, humanistic values of doctors, hospital staffs and other health care professionals aligned with the medical needs of patients, going to guide the future of medical care in this nation? Or is a governmental, budget-driven and dollar-based ethic operated by a bureaucratic, central-computer algorithm going to dictate the directions of the health care system in the United States?

The recent political debate between Michael Dukakis and George Bush blared one strident message for medicine: whoever runs the next national administration will continue to financially assault health care providers.

Michael Dukakis' Massachusetts plan, which will not be fully implemented in that state until 1992, contains elements that are embedded in the surrealistic, rather than in the rational. Massachusetts doctors have already been forcefully conscripted into a pay scheme that is dictated by Medicare and Blue-Cross/Blue-Shield. Balance billing is prohibited and strict adherence to the reimbursement schedule is mandatory for licensure by the state. The most controversial feature of the Dukakis medical program is that by 1992 all employers must provide medical insurance for all their employees. This will cost employers between $1,600 and $2,000 per worker. The total cost is estimated to be greater than $2 billion in 1993. Only the smallest businesses — with less than five employees — will be exempted. This law should devastate the Massachusetts economy as it will certainly smother marginally profitable, ongoing concerns and abort the growth and development of new, entrepreneurial ventures that are typically capital hungry during their formative years. Many established companies will have to leave the state when the economy recedes and profits fail to match the additional overhead expenses. Some manufacturers will abandon the state because the high cost will make their products uncompetitive in the marketplace. New employment will be discouraged because of the high cost to the company for each new worker.

> ***Doctors recognize that universal health-care will suddenly accelerate the high cost of medicine because it will immediately increase consumer demand for health care.***

The application of the Dukakis plan to the entire nation will probably produce an economic downturn of 1930s proportion. Most physicians reflexly reject a Dukakis-styled, national, mandatory health insurance scheme in the same fashion that they rejected the Medicare proposals of the 1960s. Doctors recognize that the program will be appended with covenants that will further restrict quality medical care — probably in a fashion more severe than the practice limitations that have been imposed during the past eight years. Doctors also recognize that such a program will suddenly accelerate the high cost of medicine because it will immediately increase consumer demand for health care. Thirty-seven million

people in the United States have no health insurance today and their use of the health care system is limited. These individuals, when financially armed with the golden bough of free health insurance, will certainly increase utilization of the health care system. Initially, this increased demand will resolve the doctor glut and refill many of the currently empty hospital beds that exist. Ultimately the huge costs comingled with the unemployment that the plan will induce (particularly in the service sector of the economy) will flood the country with an even larger number of people who are uninsured. This train of events will inevitably lead to further budget cuts for the health care sector and will most likely strangle research and capital expenditures. Hospitals will financially fail and physician incomes will slip to levels far below those of less strenuously trained professionals — such as lawyers and account. The intellectual quality and industry of people entering medicine will decline. This will hasten the ultimate dissolution of the high quality American medical care system that has provided the world with so many of the medical advances of the past half century.

Every citizen, including every doctor, applauds Mr. Dukakis' entreaty for inexpensive, quality health care for everyone. Unfortunately history has demonstrated that *his* plan for accomplishing that noble, yet ethereal, goal is a vast sargasso sea of economic sophistry.

George Bush's program for medical care suffers from a famine of original thought and projects no hope of remission from the regulatory plague of the past eight years. If elected, Mr. Bush will preserve the present Reagan policies that have pulverized the financial infrastructure of the nation's hospitals and that have so stifled economic freedom in the health care system that medical expenses have advanced at a rate that is twice the general inflation rate. Mr. Bush will permit the continuance of the HCFA regulatory turpitude that threatens to bankrupt one quarter of the country's hospitals and that will lead to the extinction of most of the rural hospitals with fewer than 100 beds. Additionally Mr. Bush wants to extend the DRG experience from the hospital to the doctor's office. The exact details of his programs have not been designed so that an approximation of their cost and a measure of their potential for desolation of the health care system cannot be judged at the present time. Thus, a Bush administration offers no relief from the present government interference in the practice of medicine and assures additional regulatory malfeasance.

Fortunately, Mr. Bush is limiting the aim of his bureaucratic howitzer to the Medicare system. He has transferred the problems of the uninsured and medically indigent to either the states or private sector to resolve.

Florida will elect one United States senator this year. The Republican nominee is Connie Mack. The Democrats will choose between Florida insurance commissioner. William Gunter, and Ocala Congressman, Buddy Mackay, in the October runoff.

Connie Mack is the Republican nominee for U.S. Senator who currently is the Congressman from Cape Coral. He has been the most outspoken friend of medicine of all the Florida congressmen. He has expressed strong opposition to the passage of any further budgetary restrictions on hospitals and other health care providers and feels that the budgetary squeeze on providers has been "too much" and "gone on far too long." He does not want to permit any further federal expansion in health care since he feels the current program is already excessively large and unmanageable. He voted against the Pepper bill for long-term home health care for two reasons: it supports home health care when the people need and want nursing home care and he was adverse to imposing another tax on the elderly. He prefers to fund home health care by granting tax credits to those families who have long-term home health care responsibilities for elderly persons living with them.

The choice between Mackay and Gunter is rather simple. Buddy Mackay has represented central Florida in the U.S. House of Representatives. He is moderate to conservative in his political philosophy. He has professed support for less government interference in the patient-physician interaction in the health care system and espouses fewer restrictions on reimbursement of cognitive physician services.

Gunter has displayed a rather inept grasp of the medical care issues that his insurance commission should have handled. He has passively overseen and abetted the pillage of the Medicare system by the IMC HMO that has been indicted for Medicare fraud and which has swindled millions of health care dollars from Florida's elderly, Florida's hospitals and Florida's doctors. He refuses to publish or relinquish data about the economic conditions of the state's HMOs or PPOs — despite this writer's repeated attempts to solicit the data from his office. He has not supported any feature of the malpractice reform efforts of the legislatures; he opposed both the MIRA and the MICA bills that presented meaningful tort reform. He has not favored any major piece of legislation that Florida medicine has proposed. He has overseen the bankruptcy of the Patients' Compensation Fund that strained the finances of Florida's hospitals and which resulted in passing through the losses to the patient population of the state. It cannot be determined

The Florida legislative landscape should be more sanguine if several physician candidates and one physician spouse win their respective elections.

whether he is inept, unprincipled, or merely an opportunistic political panderer. It is certain that he would be a disastrous representative of the citizens of Florida vis-a-vis medical issues.

Many of the issues that confront medicine will be resolved in the state legislatures and not on the national level. The success of the goals of organized medicine are dependent upon a greater involvement by doctors and their families in the legislative process. Only two physicians served in the 1988 Florida legislature: William G. "Doc" Myers is a family practitioner from Hobe Sound. He is the current Chairman of the Senate HRS Committee and has been elected by his Republican colleagues to serve as Senate Minority Leader during the 1989 and 1990 legislative sessions. Representative David Thomas is an ophthalmologist from Venice who has served two previous terms in the Florida House. He has quickly moved up in the leadership of the Republican party in the legislature and is regarded by his colleagues as an expert on health issues.

The Florida legislative landscape should be more sanguine if several physician candidates and one physician spouse win their respective elections.

Dr. James Corwin is a general surgeon who practices in Jacksonville. He served for many years on his local school board before seeking state office. He is confronted by a runoff for the Republican nomination for a seat in the Florida House in a traditionally Republican district. He placed second, by a very small margin, in the initial primary. If his staff can arouse voter turnout in the October primary he will enjoy a high probability of victory both in the primary and in the November finale.

Dr. Roy Campbell is a general surgeon who practices in Palatka. He also has served on his county school board for approximately ten years and is well rehearsed in the rigors of public service. Two years ago he lost the Democratic nomination to a strongly entrenched incumbent by a few dozen votes. He is expected to win his election in November.

Representative Susie Guber is an FMA auxilian and the wife of Michael Guber, M.D., of Miami. She won her House seat in 1986 in a close election and faces a strong challenge this year in her drive for reelection.

Dr. Ben Graber, a Coral Springs obstetrician, defeated the incumbent Representative, Joe Titone, a trial lawyer, in the recent Democratic Primary in District 89 (Broward County). Dr. Graber is running for elective office for the first time. Since 1982 he has been active in politics as a behind-the-scenes fund raiser and as an advisor on medical issues to several legislators. He honed his political training by taking the AMPAC political candidate course 18 months ago and recently was featured in a video instruction program for physicians interested in seeking political office.

Dr. Robert Shedd is a family physician in Punta Gorda. He is challenging the incumbent, Vernon Peeples, for the District 72 House seat. Dr. Shedd has been a Charlotte County Commissioner. He had no challenge for the Republican nomination in the primaries.

It is heartening that more physicians are seeking public office. This will positively contribute to the longtime concerns of every physician in the state. Each of the above candidates needs funding. The electoral success of all of them would markedly strengthen medicine's presence and influence in Florida government. As doctors, we continually moan about the legislative evils that beset us. These individuals have made huge commitments of time, money and family life in their attempt to maintain our opportunity to practice quality medicine. They need and deserve our donations. If all FMA members contributed a mere $50 (a pittance that would not leave any of us financially ill) to each of them, every candidate could amass a campaign fund that exceeds $750,000 — an amount that would assure success in almost any House election.

Acknowledgment

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Reference

1. Jackson, ER, Jr.: Health Issues and the 1988 Presidential Election, FMA Today, September 1988.

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My Son, An Organ Donor

Editor's Note: Last month, *The Journal* ran the first place winner of the Best Editorial category of the 11th Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins in the editorial section. This month we feature the remaining winners of this category as our Encores. Tying for second place were "My Son, An Organ Donor," from *Miami Medicine* and "Of Course There is A Malpractice Crisis, but Is the *St. Pete Times* for Real," from Pinellas County's *PICOMESCO Mail Bag*. Awards for special recognition went to the Marion County Medical Society *Bulletin* for "From The President," and *Miami Medicine* for "What Ob/Gyns Now Must Face." We know you will enjoy reading these award winning editorials.

I am the mother of four children. I would like to tell you about my youngest son, Scott. A special person, always, to me, but a special person to hundreds of people he never knew. Special because he made the choice to be an organ donor. I want to tell you about him, his life, his dreams, his decisions, and his death.

Scott was a typical 14-year-old boy in many ways. He was an active 9th grader at Cutler Ridge Jr. High School where he quarter-backed on the football team, swam on the school swim team, and marched with the band. Last year he won the MVP award for swimming. The stereo was always blastin; the better to "jam" with. I sure miss that "noise"; it greeted me every day as I came in from work. He and his older brother, Chris, would play the drums for hours. Scott was an average student, very proud of the fact that he was finally understanding algebra. Girls were on his list of interest, but had not yet moved above football or playing his drums. I knew they noticed him because they constantly teased him about his curly hair. I asked once if the girls were giving him a hard time, he replied, "Yeah, they just love my hair." I guess Scott's greatest love was that of the Georgia Bulldogs. He collected Georgia memorabilia with a passion. His room was a "Dawg" showplace, from his blankets to the wallpaper. He loved "them Dawgs."

On Jan. 3, 1986, Scott and his brother, Chris, were on their way to the barber shop. They never made it! The VW Beetle in which they were riding collided with another car. Chris' right arm was almost severed. Scott was thrown from the car. I came upon this scene: emergency vehicles, flashing lights...and my children. Air Rescue rushed the boys to Baptist Hospital. I cannot begin to tell you the feelings of pain, fear, and total helplessness that I felt that terrible day. And it had only just begun.

Scott was 12-1/2 years old when he signed his donor card. We have always encouraged our children to be independent, to think for themselves, to ask questions, and we have tried to answer those questions as honestly as possible, no matter how uncomfortable the discussion might become for us. We do not always agree on ideas, and they are free to express their views. It's amazing the insight many young people have about life and death. It was in one of these discussions that organ donation was approached.

My husband, Charles, a fire chief for the city of Hialeah, was completing the information on the back of his driver's license. Scott was watching. His questions began, "Why are you doing that, Dad? What's it for?" They talked about what this card stood for, the commitment it represented. Scott thought it was a good thing to do and asked for a card of his own. He carried that card in his Ga. Bulldog wallet, along with a picture of his family, and his favorite photo of UGA, the mascot for the U. of Ga. These things were important to him! That wallet was in the waistband of his jeans at the time of the accident. Some might wonder, "If that information was there, did he get the best treatment available? Did the medical staff work to save his life or to save his organs?"

I'm very comfortable in knowing that the treatment my son received at Baptist Hospital was outstanding. Specialists, nurses, support personnel did everything humanly possible to save Scott's life. They worked hours in the ER, giving him their all. We stayed with him in the critical care unit all that night, hoping, praying for some sign of improvement. The life support systems hummed and beeped. His chest moved up and down as if breathing, the heart monitor said his heart was beating. I kissed him. He was warm and soft. He looked as if he were sleeping. "My baby can't be gone," I told myself. But as the hours passed, there was no change. Doctors examined him all through the night. The nurses attended to him around the clock, giving of themselves far beyond duty. We were told that tests would be given to determine if there was any activity in the brain. These tests were administered twice at different intervals. The results were the same, no activity. The machines were doing for Scott what his brain could no longer direct his body to do. Scott was brain dead.

The unit nurse approached us about organ donation. A decision to be made at a point of deepest despair, but that decision had been made almost two

years before. Scott had made his wishes known. I look back and say, "Thank you, son, for helping us make the choice."

Scott was buried wearing his prized Bulldog jacket and his red "Junk-yard Dawg" cap. More than 500 mourners came to pay their respect to this young man. The fact that his organs had been removed was not evident to a single person there. Skillful surgeons had taken as much care with his operations as they would have taken for any other patient. He rested peacefully, his drumsticks clutched in his hands, his favorite pennant and button pinned nearby. We said good-bye.

The University of Georgia's coach, Vince Dooley, awarded Scott the highest honor bestowed on their athletes, the varsity "G." He is officially a varsity letterman for his beloved school. His classmates held an organ donor awareness day in his memory. Thousands of dollars were contributed to different charities in his name, an elementary school planted a tree. Remembrances continue every day.

I don't know why this terrible event happened. I do know that Scott left a legacy of hope and love. Because of his generosity and maturity not even recognized at the time, four other human beings are living better, happier, and healthier lives. Two men each have a functioning kidney, Scott's kidneys. Two others can see a brighter world with the help of Scott's corneas. In Atlanta, his heart valves, frozen, wait to answer a need.

We have no way of knowing just how many lives Scott touched. I can tell you that there is comfort in the knowledge that his life was not wasted or that his death was not an ending of him. Through Scott there are new beginnings. I stand in awe of this young man.

We are very fortunate to live in a time when medical science can offer avenues for a new life. What a few years ago was a prayed for miracle is now a reality. A new kidney to replace a defective one, eyes to see again, a new heart for a diseased and dying one. We now have an opportunity to be a part of these miracles. Each of us has something to leave behind that will benefit our fellow man. Be it a usable organ or tissue for transplant or for research, it is our gift. We discuss with our families, our lawyers or our ministers what to do with our material assets when we leave this life, how to bury us and where. We insure ourselves so that in the event of our death, our loved ones will be cared for. We write last wills and testaments to preserve our wishes and to lighten the burdens of those we leave behind. I suggest that our wishes regarding what to do with our salvagable parts is as important. Discuss with your family what your answer would be if asked to be an organ donor. What answer would you want them to give in your regard? How do you feel about the question? If you are hesitant to say "yes, use my organs," then ask yourself "If my loved one needed, if I needed, would someone say 'Yes' to my plea?"

Scott's act of organ donation has been a great comfort to us. It is an aspect of his life so important that it has been placed on his tombstone. Scott liked to speculate about the person buried, by what was inscribed on his tombstone. With that in mind, we set about to design a monument that would tell the world about our child. The usual facts are there: name, dates of birth and death, that he was a beloved son and brother. But also inscribed in the granite is a poem, written by a firefighter, that tells of Scott's love for people and his love for the "Dawgs." A carving of the Bulldog, in red and black, with the fact that he is a varsity letterman, stands out. The etching of a swimmer graces one side of a huge heart, a drum and sticks on the other side. In the center of the heart is Scott's picture, preserved in porcelain, and underneath his picture reads ORGAN DONOR.

He is remembered with love and laughter and sadness and pride. I am grateful to have shared 14 years of my life with him. He is missed...

Linda McBeath

Reprinted with permission from Miami Medicine, Dade County Medical Association, May 1987.

Of Course There Is a Malpractice Crisis, but Is the St. Petersburg Times for Real?

Uniform agreement ranks the 10 best newspapers in the U.S. but does not name a second 10, which could possibly include the *St. Petersburg Times.* It claims to be the best newspaper between Miami and Washington, D.C. and has journalistic credits, circulation and net worth to support this claim. It has surpassed the *Atlanta Constitution, Baltimore Sun* and Richmond and Norfolk papers and now is endeavoring to leap-frog over the *Miami Herald* as number 10 and waging a turf war with the *Tampa Tribune* for further advertising revenues and subscribers.

Crisper in appearance and print than the number one *New York Times* it is more fun to read since it blends world news with *black* news of violence and scandal from the streets. It has more color and graphics than *USA Today,* special features to equal the *Philadelphia Inquirer,* and its sports and comics rival the rest of the top ten. Alas, Colonel Hoople and the characters of Toonerville Trolley which disappeared from its comics seem to have taken over it's editorial columns. Voters are learning to heed its recommendations but vote the opposite. Bias and poorly supported views from a friend at a smoke-filled party may seem witty, or be easily tolerated or ignored, but are not acceptable in the morning editorials.

Its editorials have continued to deny a malpractice crisis, even in 1974 when Argonaut withdrew liability protection from most Florida physicians and in 1987 when CIGNA and St. Paul's are leaving. Its own news pages state that malpractice suits and awards are soaring and premium rates have tripled in Florida, with similar problems in other states. There is a breakdown in ER, OB and neurosurgical care due to excessive malpractice risks. Repeated efforts by the Florida Legislature to provide relief through tort reforms have failed or been ineffective, with no assurance that a special legislative session will succeed. Meanwhile, its editorials maintain that no crisis exists, so doesn't need fixing. Its editors, while publishing the *Congressional Quarterly,* a national and international political news source, must have wide access to news and computerized information, but ignore or even shred contrary information. An editorial is an option, but the reader deserves the right to know facts.

Since the *St. Petersburg Times* editors are unable or unwilling to acknowledge a malpractice crisis, your PICOMESO Editor will write an editorial for them. Pretend you are reading it in the *Times,* not here.

Urgent Need for Malpractice Problem Solution

From 1975-85 *medical malpractice* awards increased by 835% in the U.S. This increase began in 1960 and is continuing. Eighty percent of related injuries occurred in hospitals and the cost to hospitals and M.D.s increased from $2.5 billion in 1983 to $4.7 billion in 1984, with an average award of $81,000. In 1984 43% of all claims were settled out of court. More than 37% (1/3) of all M.D.s will have at least one claim filed against them, and 42% of all M.D.s sued will have had at least one earlier claim. 65% of OB-Gynecologists; and 50% of all surgeons have had 1 claim filed. *St. Paul's,* the largest medical malpractice insurer in the U.S., reported an increase from 4.3 claims per 100 insured physicians in 1970 and 7.8 claims in 1976, to 18.3 claims per 100 physicians and average awards increasing from $23,282 in 1982 to $46,648 in 1986. Of course, total costs per average claim are much higher due to legal costs. These more than doubled in Florida ($42,454 in 1982 to $103,128 in 1986). *St. Paul's* paid more than $36 million in Florida in 1986 for awards and defenses, with 1,800 cases still unsettled and the 4 year statute of limitations permitting more claims to be filed. This is 39% higher than the $26.2 million paid in 1985 and in 1984, payment was $9.7 million. *St. Paul's* and *CIGNA* attempted to drop the 7,000 M.D.s insured in Florida in 1987 and will stop all U.S.A. coverage in 1988. *Argonaut* withdrew from Florida in 1974 and stopped all U.S. coverage in 1986. Several physician-owned insurance companies are in economic straits. In 1974-75 premiums for doctors rose by 286% in Florida, 145% in California and 193% in Tennessee. Repeated legislative efforts in these states to control costs have failed to check annual increases in premium rates.

What has caused the rise in malpractice costs? Our society seems always to expect perfection and has a strong litigious state of mind, yet malpractice cases are increasing at a rate twice that for other liability cases. Are there more bad doctors? Doctors now receive longer training and there are more specialists

than ever, annual postgraduate education is mandatory, licensing boards are stricter and there has been Peer Review and Risk Management supervision at hospitals for five years. Are there more avaricious lawyers? Certainly the U.S. has more lawyers than other countries and these have discovered the possible large awards from malpractice or product liability cases. Is it the system in our courts? Since 1975 almost every state has attempted tort reforms by limiting period for filing a suit, utilizing boards to determine the merits of a case before accepting a claim, putting fixed limits on contingency fees and ceilings on non-economic awards for pain, suffering, punitive charges, etc. None have been highly successful. Are insurance companies after excess profits as consumer groups and trial lawyers claim? It is not reasonable to assume that these are increasing numbers of claims or amounts of awards at their own economic peril. Reinsurance companies in Britain, once the backbone of the U.S. malpractice liability industry, have dropped U.S. markets due to high risks. The 1987 U.S. General Accounting Office Final Report on Malpractice to the Congressional Record (GAO MRO/87-73) provides most of the above statistics and concludes that there are no clear answers. It suggests that remedy must entail radical change or abandonment of the tort system, immediate public education and increasing doctor accountability.

American law traditionally derives from English law; yet there are marked differences as applied to malpractice and there is no *crisis* in the UK. There contingency fees are unlawful, and there are no awards for non-economic reasons as pain, suffering, etc. There are no juries in malpractice cases, and the judges seem to protect the National Health Service and its hospitals and doctors from large awards, high court costs, changing the standards for reasonable care, or the need for costly defensive medicine. Access to medical records is very difficult, and many claims have to be filed and refiled before their worth is accepted. Legitimate suits are settled rapidly but all "nuisance" suits are fought. Allowances for future medical care of anyone injured are low since the NHS provides this. Joint responsibility ("deep pockets") is not recognized; so that several treating physicians and the hospital are not placed in adversary positions, to the advantage of the plaintiff.

In America, many lawyers have long regarded the tort system as an inefficient way to attempt to compensate for medical injury and since 1975 Dean J. O'Connell of the University of Illinois and now the University of Virginia Law School has proposed legislation for a No-fault malpractice panel to make uniform awards. M.D.s find the tort system unacceptable since 3/4 of claims filed are not medically substantiated although many of these receive large awards while no more than 10% of these awards lack uniformity. Our present court system seems to give rise to a *money tree* that is growing wildly despite efforts at control by state legislature through more and more tort reforms, by the State Insurance Commission through tighter controls, by medical boards through closer supervision of doctors, by public awareness and by increasing out of court settlements. The fair recognition and compensation of any medical injury should not permit a mushrooming money cloud to dominate. It should not permit paying up to $6,000 or more in "finders fees" to referring attorneys or hospital snoops, or 50% contingency fees to the plaintiff's attorneys without regard for actual works performed, or the payment of $3,000 to $5,000 to the 3,000 medical experts who are available to screen, advise, or testify in a single case, permitting them a possible annual sub rosa income of up to $200,000. It should not permit juries to award millions in the futile effort to compensate for lives or injuries that cannot be restored. It should not permit attorneys for both sides to increase their fees by dragging out a case. In the past, attorneys have refused a case that did not promise a $50 thousand award and now the amount is said to be $100 thousand. When insurance companies raise their rates without justification, this is a response to the money climate that prevails in the court. In a Catch 22, larger awards and more suits bring on defensive medicine and raised costs and thus still higher court awards for future medical care. Contamination of judges, bailiffs, and court clerks by payments for favors has been reported in some states.

However complex the malpractice problem has become, an urgent remedy is necessary. The impact of cash is certainly reduced by structured payments over the projected lifetime of the claimant instead of a lump sum. Even better would be the award of cash vouchers restricted to specific uses for training, hospital or medical care, food or shelter, clothing, or vehicle for the injured. Removing malpractice from the courts in favor of No-fault awards by a non-judicial panel, as with Workmen's Compensation and No-fault automobile insurance should permit uniformity of awards and control of total costs. The courts could still be available to any plaintiff not accepting this route. Contingency fees may seem sacrosanct in granting even the poorest citizen a day in court, but with $30 billion spent in suits last year, there must have been sufficient funds to provide free legal representation for the poor without the need for contingency fees. The Governor and the Insurance Commissioner and the legislature may be able to achieve a stop-gap solution to the malpractice crisis, but the judges of our state have the greater responsibility and knowledge to affect a permanent solution.

Elmer B. Campbell, M.D.

N.B. Pretend you read this editorial in the *St. Petersburg Times*, then it must be true!

Reprinted with permission from the *PICOMESO Mail Bag* of Pinellas County Medical Society, Inc., October 1987.

From the President

Several weeks ago, I had the occasion to take my car in for repairs. As it was still "under warranty," it was a relatively painless procedure. Nonetheless, it was highly inconvenient. No "loaner car" was available, so I was forced to obtain a rental car for transportation that day. In the process of doing so, I ran into a retired businessman who was also obtaining a rental car for the same reason. Both of us were equally upset over the whole situation and the conversation went as you might have predicted. "Things have really changed," he said, "no pride in workmanship, no service, nothing ever built to last." He also commented that "this is truly a sad state of affairs these days." I, of course, fully agreed with him, as my car was only a few months old and was already having significant problems. Then the time came to sign the contract agreement for the rental car. By this time, my beeper was going off every two minutes and I was late for rounds, so he courteously allowed me to go first. The salesman asked, "Do you want theft and accident insurance, and how about an umbrella coverage for liability?" and I replied, "Of course, it's only $5.00 more per day and you certainly can't be over-insured these days." "Okay," he said, "that will be $28.00. Please sign here, here, here, here... Your car will be ready in just a minute." It was the businessman's turn next. And to the same questions, he replied "No, I don't want any extra insurance" and "What do you mean $23.00 per day? I was told it was only $18.00 per day." "Well, sir," replied the salesman, "that rate is for compact cars and we are all out of those today." The businessman argued on. "That is not what I was told at the dealership when I agreed to come for this rental car." Then said the salesman, "I can see your point...perhaps we can knock a little off of the price." And he did.

I have thought repeatedly about that interchange, and feel that it is a reflection of the marked divergence of values shared not only by that businessman and myself but by the business community and the medical profession in general. It was also my understanding that I was to be given a compact car for less money, but when confronted with the situation,I responded quite differently. My overriding concern at that point was to get to my patients and solve the various problems facing me that day. So what if it was a little more expensive. I'd rather ride in a bigger car anyway and I'd rather be "covered" than run the risk of having insufficient insurance, even though I wasn't certain exactly what my policy would cover. To the businessman, however, the proposition was quite different. His overriding concern was to provide pure, simple transportation at the cheapest possible price. And that is in truth the business standard — purchase the lowest priced item that will do the job. That has been the driving force in the American economy since the industrial revolution. People who adhere to this standard will be the ones who succeed in business. True craftsmanship, attention to detail and pride in workmanship are really more "old world" values. They are retained only when a profit can be made by doing so. An example of this is that "quality is job one" became a by-word only when there was a sales slump. The complaints that we all have about American products and service are truly a logical consequence of this standard. Had it been profitable for our cars to be made to a higher production standard, we would all be returning them for repairs much less frequently. True, there are those connoisseurs of automotive craftsmanship who drive Mercedes; however, you must admit that they are in the minority. The vast majority of Americans are not willing to pay the extra price, and they are willing to put up with the inconveniences and poorer quality for the lower price.

On the other hand, I feel that my attitude typifies that of most physicians and their patients. How many times have you heard "Do everything, doc, we want only the best"? "Okay, then, let's give him 10 vials of Gorillacillin IV STAT and get the brain transplant team ready."

We in the medical profession have been, until recently, isolated from the mainstream of financial reality and have, to a large degree, retained old world standards and values — a sense of pride in the quality of our practice, taking the best possible care of our patient not only for the patient's sake, but for the sake of the medical profession and worrying about the costs of that endeavor at a later time. There is nothing in the Hippocratic Oath that says we will administer the most cost-effective treatment to our patients. "Cost-effectiveness" is a new concept to our profession.

We now stand at a major crossroad in the history of our profession. No longer will we be given a free hand in the healthcare decision-making process. Society, the government and the third-party payers have decreed that is too expensive. An all-out campaign is now being waged to lower healthcare costs. To this end, our Federal Government has turned to DRGs, MACs, PROs and Gramm-Rudman for solutions. They have made it amply clear to us that their overriding concern is to cut costs — at all costs — even

if they have to disguise this as "quality issues." Private industry (until recently it has always sounded good to me) has turned to HMOs, PPOs, pre-admission criteria and a variety of creative avenues as their tools in the conquest for the Holy Grail of cost containment. If medicine is to be run on the business standard, then the end result will be a compassionless system focused on the bottom line and unconcerned about the final product unless it affects the profit and loss column.

Personally, I do not think that would be very healthy. How would you like to be on a respirator bought from the lowest bidder and manned by minimum wage employees? So, just as it has become abundantly clear to all of us that the Federal Government does not understand how to "establish a healthcare system" that can provide quality care at a reasonable price (or at least doesn't seem to be willing to do so), it does not appear that private industry, left to its own devices, will be able to do so either. In fact, the only ones who understand how to achieve that end are the physicians themselves and there have been precious few attempts to solicit our input into the decision-making process. What the future practice of medicine will be is anyone's guess. But, one thing is certain — retaining the high standards of medical care our patients now enjoy will not come through either private industry or a government alone. One can choose to sit passively by and say "I told you so!" when the public becomes disillusioned with both of these approaches. It will take years for American medicine to recover from this fiasco. I suggest to you that we need to take a more aggressive approach on all levels. We need to teach our patients and the third-party carriers about true quality in medicine. We should all write frequent letters to our congressmen on this issue, talk to our patients and anyone else who will listen, and participate in organized medicine as it attempts to carry out these ends on our behalf. Lastly, if you choose to join an HMO or PPO, become active in their advisory boards and do your best to insure that they are truly concerned about providing a healthcare program that will deliver quality medical care.

We in Marion County have been spared from many of the problems that our fellow physicians have had to face around the state dealing with the various private industry created healthcare systems. We can insure that the tradition of providing our patients with the best possible care at a reasonable price continues only by our continued insistence that it do so for, if we fail to help define true quality in our healthcare system, rest assured that someone else will...and the final version of this definition will not be found in any medical dictionary.

William A. Trice, M.D.

Reprinted with permission from the *Bulletin* of the Marion County Medical Society, January 1987.

What OB/GYNs Now Must Face

While the journalistic forum editorializes on the malpractice crisis and the plaintiff and trial attorneys minimize or deny that such a crisis exists, when will the public not only listen to what is being said but understand and be sensitized by what we physicians are really saying?

I think I can very graphically demonstrate, with a case presentation, the problem that exists in our specialty in particular. I will preface this presentation by a few facts about my personal background.

It was 30 years ago, as a junior in medical school, that I decided to pursue my future as an obstetrician and gynecologist. For those 30 years, I have had the privilege and opportunity to bring new life into the world. I feel that I have had excellent training at the University of Miami School of Medicine through my internship and residency programs. I have had vast experience in my specialty through many years of private practice. I have essentially devoted my life toward professional excellence with sincere regard for the safety and welfare of my patients. With this background recognizing the frailty of human effort, this case presentation represents the vulnerability and frustration of the practice of obstetrics at this time.

Mrs. Smith (not her real name) was 12 days past her expected date of confinement and on my examination at 7:30 a.m., July 1, 1987, she was found to be in very early labor. At that time, I met her husband. He had taken the childbirth education classes and he was of the understanding that at this particular hospital, 30 percent of all patients have a cesarean section. He wanted me to know initially that he did not want his wife to have a cesarean section. He was already disturbed that his wife was already 12 days post date and I sensed a slight degree of resentment in his communication with me at that time.

At noon, I returned to observe the course of her labor and remained in attendance for two hours. She was making very slow progress, I ruptured her amniotic sac at that time. There was clear fluid

indicating that the baby was in no distress and the fetal heart tones were perfectly normal. After the examination, I sat at the telemetry station to observe the fetal heart rate pattern for a period of time; this area is located approximately 15 feet from the patient's bedside. The labor room nurse in attendance reported to me on two occasions that she had noted that the fetal heart rate had dropped to 90 bpm with prompt recovery. The normal fetal heart rate is between 140-160 bpm and there was absolutely no significance to this drop yet, but to protect herself and the hospital, she recorded, on the medical record, the four different time frames that she had noted a slight drop in the fetal heart tone and the time when she notified me accordingly of this abnormality.

If this document were ever presented in the courtroom obviously it would not look well to see that the nurse recorded an event where the heart rate decreased, the doctor was notified and no action was taken. Since the advent of electronic fetal monitoring, an obstetric patient who is admitted will have a continuous record from the time she is admitted until the time she delivers and any abnormal fetal heart rate pattern will be documented. That entire record, unfortunately, will be subject to interpretation and will almost always be detrimental to the obstetrician.

At 7:30 p.m., I returned to the hospital to stay with the patient for the duration of her labor. She was now 4 cm. dilated and having irregular contractions and at that time I initiated the use of Oxytocin to stimulate and improve the quality of her labor pattern.

At 10:00 p.m., she was 5-6 cm. dilated, extremely uncomfortable and was desirous of epidural anesthesia. Her husband had become somewhat uncommunicative with me as if I was responsible for his wife's long labor and suffering. The epidural anesthetic was given by an anesthesiologist which alleviated the pain so successfully that it stopped her effective contractions despite the use of the stimulating agent, Pitocin.

At 1:00 a.m., she was now 7 cm. dilated with progress of the fetal head descending through the birth canal. I had been very patient. I did not feel that there was any need for surgical intervention at this time, but then my concern and anxiety level intensified because this labor pattern was somewhat different from normal. I asked myself, is there a reason for the unusually slow progress, is the baby too large?

At 3:00 a.m. the nurse related to me that the fetal heart rate was now 160-170 bpm. This suggests some degree of fetal tachycardia which in itself is not of significance but, again, in the courtroom the plaintiff would certainly make a case for fetal distress at this point. This pattern continued for 20 minutes and then a normal fetal heart rate pattern resumed.

At 5:00 a.m., the nurses encouraged the patient to push, the effectiveness of the epidural had worn off and she was ready to be taken into the delivery room. I had been patient and judicious in my management to this point. For 10 hours I had been in constant attendance near the patient's bedside. Now I ask myself, will I need to use outlet forceps to deliver this baby? Will I possibly encounter a difficult time delivering the baby's shoulder through the vaginal outlet? Is the baby too large?

The fetal heart rate was excellent, the baby's head was on the perineum and in preparation for delivery. I asked the nurse to give me a pair of low outlet forceps. The nurse looked at me as if I had committed a gross error in judgment. She has probably not seen forceps being used frequently. She is trying to be protective of the patient and the patient's child. For the first 15 years that I was in practice, probably 99 percent of all the patients that we delivered, low outlet forceps were used. However, my anxiety at this time and stress level was at a maximum level. I can recall two medical legal situations involving colleagues of mine that had gone to court because of the use of low forceps with no damage to the infant other than traumatic associated deliveries.

At 5:31 a.m., I delivered successfully for this patient and her husband, a healthy 7 lb. 10 oz., full term male infant without complications.

Does this experience sound like I was having fun? Do I have to say that I was both totally physically and emotionally exhausted?

The husband was reluctant to shake my hand when I congratulated him. That was his appreciation for my care and concern for his wife. I realize that had there been an adverse outcome, there were six different occurrences that a plaintiff would attempt to label me negligent and guilty of malpractice.

Doesn't it seem that the practice of obstetrics, recognizing our total vulnerability regardless of our intensity of care, has to label us as supreme masochists? I might be one of the oldest living obstetricians who continues to perform this specialty. I will not give up, but I will fight to help change the system.

Every doctor/patient relationship in each and every specialty is strained by the cloud of total expectation for perfection. The legal profession has really perpetrated this climate to discontent. Ninety-nine percent of quality physicians have been so sensitized that their whole perspective on the practice of medicine has been distorted. We only want an equitable solution to this problem for the patient and the physician. We want to eliminate the large and certainly unjustified verdict awards activated by the successful theatrics of the plaintiffs' attorneys. The only solution in my opinion is to change the tort system by arbitrating each situation honestly and fairly outside of the courtroom scene. This is very simplistic but it is toward this just goal that we should strive.

Medical care has never been so complex, far-ranging and successful. It is so vital that we organize as a group to unload this disastrous burden and be allowed to devote our energies toward the excellence in medical care which our patients so richly deserve.

Henry I. Glick, M.D.

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FLMD988

ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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If there is any one thing Mrs. Arthur (Jane) Eberly would mention as the most important contribution to her upbringing, it is that a person is *required* to become involved in the politics and public service of the community from which one prospers. That is one of the reasons her choice of the theme, "Concern, Change, Challenge," is so appropriate for the 1988-89 Auxiliary year. Growing up on the family farm in central Indiana, Jane was active in the 4H Club and other projects, receiving numerous state awards. Her political interest was inherited from her father and grandfather who were always involved in local politics, having been elected to the county commission, council, and school board. Jane credits her organizational and leadership skills to her community involvement during those early years.

Mrs. Arthur (Jane) Eberly

The only one of her 29-member high school graduating class to further her education, Jane was a practicing registered nurse at the time she met her future husband, Arthur, who had come from the University of Miami to Indianapolis to do an internship. They were married in 1961 and came to Lighthouse Point, where Dr. Eberly began a family practice.

When the Eberly's settled in Lighthouse Point, Jane continued the family tradition of volunteerism. As a FMA Auxiliary member, she has served on the Finance Committee (three years), Nominating Committee, Long Range Planning Committee, Ad Hoc Committee on Insurance and Strategic Planning, and as Chairman and member of the Bylaws Committee. She is a member of the FLAMPAC Board and received the Distinguished Service Award in 1983. Other positions include State Convention Chairman (two years), South District Vice President (two years), State Membership Chairman (She received the State Membership Award in 1985.), Recording Secretary, FMA-A First Vice President, and FMA-A President-Elect.

At the county level, Mrs. Eberly was president of the Broward County Medical Association Auxiliary, North Branch ('67-'68), and president of the Association Auxiliary ('81-'82). Other positions include the Bylaws and Resolutions Committee, Standing Committee on Legislation and Political Action, and Counselor, Broward County, North Branch. Jane has served on the Candidates Election Committee of the county medical society and was a MAT leader.

Community projects include an appointment to the Code Enforcement Board of Lighthouse Point (a position she still holds), and membership on the Special Events Committee. Jane was instrumental in forming the American Cancer Society, North Branch, in Pompano Beach, Lighthouse Point and Deerfield Beach. During the first two years of her service for the American Cancer Society, she was Income Development Chairman. She subsequently served on the Education Committee and has also been secretary for the organization. Mrs. Eberly is a deputized voter registrar and has served on the Election Board in her local precinct.

The church has always played an important part in Jane's life. She and Dr. Eberly belong to the Trinity United Methodist Church in Lighthouse Point where she has served as a Board member for the past 14 years. Jane has been a trustee, director of personnel, and presently chairs the Worship Committee. She also taught Sunday School for a time.

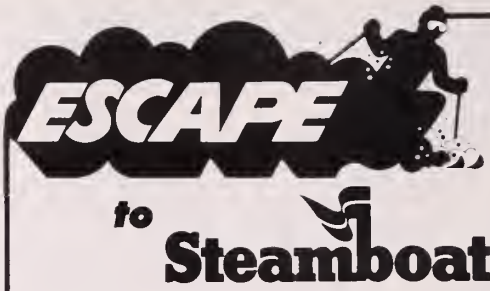
Mrs. Eberly has passed on her love of community involvement to her three children. Sons Arthur III and John are senior medical students at the University of South Carolina in Columbia. Daughter Sarah received her BA degree in political science and plans to be married in December.

After years of part-time nursing (filling in for vacationing employees, etc., in her husband's office), Jane

(Continued)

began working full time two years ago. When Jane has an extra moment, she indulges in her hobbies of golf, gardening (She is a member of a local garden club.), cooking and entertaining. She also enjoys traveling when she gets the chance.

Mrs. Donald (Renee) Winkler
St. Augustine



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Visiting Professor Series, Nov. 1-3, Miami. Contact: Peeny Ripple (305) 547-6411.

Traumatic Spinal Cord & Head Injury, Nov. 3-4, Holiday Inn, Pensacola Beach. Contact: Rose Marie Harvey (904) 474-5358.

Magnetic Resonance Imaging, Nov. 7-11, University Diagnostic Institute, Tampa. Contact: Martin Sillbiger, M.D. (813) 974-2538.

Breakfast and Learn, Nov. 10, Doctor's Hospital. Contact: Lynda R. Colaizzi, M.D. (305) 549-6857.

Cardiac Update, Nov. 10, FSU Conference Center, Tallahassee. Contact: Mollie Hill (904) 877-9018.

Pediatric Cardiology, Nov. 10-13, University Medical Center, Plantation. Contact: Dr. Richard Zackheim (305) 662-8301.

Florida Society of Clinical Hypnosis, Nov. 10-13, Miami. Contact: Linda K. Tower. (305) 547-2000.

Risk Management Seminar, Nov. 12, Airport Hilton, Tampa. Contact: M.P. Demos, M.D. (800) 431-3878.

Pediatric Care Network, Nov. 16, Miami. Contact: Dr. Nieves/Dr. Wurm (305) 549-7600.

AIDS Lecture Series, Nov. 17, Miami and Ft. Lauderdale. Contact: Richard Burton (305) 547-6867.

Directions in Pediatric Hematology/Oncology Care, Nov. 17-19, Harbour Island Hotel, Tampa. Contact: Cindi Butson (904) 375-6848.

ACLS Provider Course Provider Course, Nov. 26-27, University South Florida, Tampa. Contact: J. Paul Michlin, M.D. (813) 251-6911.

DECEMBER

Breakfast and Learn, Dec. 1, Doctor's Hospital. Contact: Lynda R. Colaizzi, M.D. (305) 549-6857.

Risk Management Seminar, Dec. 3, Holiday Inn Calder, Miami. Contact: M.P. Demos, M.D. (800) 431-3878.

Tutorial Courses of Instruction In Acute Cardiac Care, Dec. 5-10, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Gastrointestinal Endoscopy, Dec. 7-10, Buena Vista Palace, Lake Buena Vista. Contact: Worth Boyce Jr., M.D. (813) 974-2034.

Pediatric Cardiology, Dec. 8, University Medical Center, Plantation. Dr. Richard Zackheim (305) 662-8301.

Clinical Allergy & Immunology for the Practicing Physician, Dec. 8-10, Lake Buena Vista. Contact: Richard Lockey, M.D. (813) 972-7631.

First Annual Ocala Cardiovascular Day, Dec. 10, Ocala Hilton, Ocala. Contact: Rhonda Grubbs (904) 351-7206.

Risk Management Seminar, Dec. 10, Hyatt-Regency, Miami. Contact: Ronna Davis (904) 385-4935.

Basic Trauma Life Support, Dec. 10-11, Univ. South Florida, Tampa. Contact: James Hillman, M.D. (813) 251-6911.

Magnetic Resonance Imaging, Dec. 12-16, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Pediatric Care Network, Dec. 21, Miami. Contact: Dr. Nieves/Dr. Wurm (305) 549-7600.

JANUARY

G.S. Wise Postgraduate Seminar of the Dept of Surgery, Jan. 5-7, Alexander Hotel, Miami Beach. Contact: W.T. Bouck (305) 687-1367.

12th Annual Oral Pathology Review, Jan. 7-11, Hyatt Regency, Miami. Contact: CME Department (305) 547-6716.

21st Annual Postgraduate Seminar in Adult & Pediatric Urology, Jan. 9-12, Intercontinental Hotel, Miami. Contact Charles M. Lynne, M.D. (305) 547-6630.

21st Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 10 & 12, Hotel Intercontinental, Miami. Contact: Victor A. Politano, M.D. (305) 687-1367.

Pediatric Cardiology, Jan. 12, University Medical Center, Plantation. Contact: Dr. Richard Zackheim (305) 662-8301.

34th Annual Cardiovascular Seminar, Jan. 13-14, Manatee Civic Center, Bradenton. Contact: Melissa S. Crater (813) 867-5000.

Magnetic Resonance Imaging, Jan. 16-20, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Diabetes Mellitus: Optimizing Treatment, Jan. 16-20, Jackson Medical Towers. Contact: Della Matheson, R.N. (305) 547-6504.

Topics in Pediatrics: 1989, Jan. 19-21, Lake Buena Vista Place, Orlando. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Tutorial Courses of Instruction In Acute Cardiac Care, Jan. 23-28, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Visiting Professor Series, Jan. 24-26, Miami. Contact: Penny Ripple (305) 547-6411.

Arrhythmias: Interpretation, Diagnosis and Management, Jan. 27-28, Boca Raton Resort, Boca Raton. Contact: Deborah Wilderson (305) 798-9682.

8th Annual Perspectives on New Diagnostic & Therapeutic Techniques in Clinical Cardiology, Jan. 27-29, Walt Disney World. Contact: Registration Secretary 800-253-4636.

Critical Care Medicine, Jan. 31-Feb. 1, Sheraton Royal Biscayne, Key Biscayne. Contact: Dept. of CME (305) 547-6716.

FEBRUARY

Strategies in Critical Care — 1989, Feb. 1-4, Sheraton Royal Biscayne. Contact: CME Department (305) 547-6716.

A.S.P.E.N.'s 13th Clinical Congress, Fontainbleau Hilton, Miami Beach. Contact: Karen MacFirland (305) 587-6315.

Magnetic Resonance Imaging, Feb. 6-10, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Neurological Update — 1989, Feb. 7-11, Sheraton Bal Harbour, Bal Harbour. Gloria Allington (305) 547-6716.

Cardiopulmonary Rehabilitation, Feb. 13-16, Orlando. Contact: Michael Pollock, Ph.D. (904) 392-9575.

Florida Thoracic Society's 11th Annual Pulmonary Wintercourse, Feb. 16-19, Contemporary Resort, Lake Buena Vista. Contact: Richard Doggett (904) 743-2933.

Immunoconjugates Monocolonal Antibody Based Imaging, Feb. 17-19, Contemporary Resort, Walt Disney World. Contact: Dr. Aldo Serafini (305) 549-7955.

Current Status & Future Dir. of Imm. Mono. Ant. Based Imaging and Treatment, Feb. 17-19, Orlando. Contact: Division of CME (407) 547-6716.

Diagnosis & Management of Respiratory Diseases, Feb. 17-19, Sonesta Beach Hotel, Key Biscayne. Deborah Wilderson (305) 798-9682.

14th Annual Review & Recent Practical Advances in Pathology, Feb. 20-24, Fontainebleau Hotel, Miami Beach. Contact: Marie Valdes-Dapena (305) 549-6437.

12th Annual Meeting of the American Society of Neruoimaging, Feb. 22-26, Grosvenor Resort Hotel, Orlando. Contact: Susan E. Syrstad (612) 378-7240.

Problem Oriented Approach to Vitreous Surgery II, Feb. 27-Mar. 1, Miami. Contact: Gaby Kressley (305) 326-6031.

MARCH

21st Teaching Conference in Clinical Cardiology, Mar. 1-4, Sheraton Bal Harbour, Miami. Contact: Michael Gordon, M.D., Ph.D. (305) 547-6491.

Breast Disease Update VI Seminar, Mar. 1-4, Hilton at Walt Disney, Lake Buena Vista. Contact: Mrs. Esther Cohen (305) 674-2311.

Infertility & Reproductive Endocrinology, Mar. 2-4, Key Biscayne. Contact: Betty Spurlock (202) 863-2541.

Diabetes Mellitus: Optimizing Treatment, Mar. 5-10, Jackson Medical Towers. Contact: Della Matherson, R.N. (305) 547-6504.

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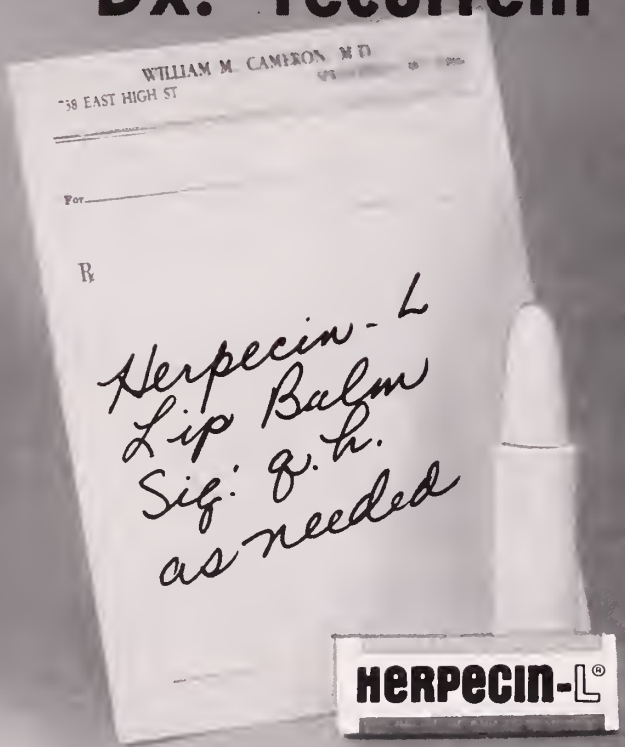

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14th ANNUAL REVIEW IN PATHOLOGY, February 20-24, Univ. of Miami, Fountainebleau Hilton, Miami Beach. Contact: Jessie Hechavarria (305) 549-6437.

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Feature Editor — **Dale C. Havre, M.D.**

Apathy Is Gold for the Lawyers

If you were a cat burglar and had to select a house for your nightly break-in, which one would you pick? In order to get the most for your risk, you would surely select a home in a wealthy neighborhood. Then you would peek in the windows to determine which dwelling contained the most valuable and "fenceable" items. If your flashlight revealed a floor devoid of carpet, flimsy stainless steel utensils in the sink, and a TV set without an umbilical attached to a fancy VCR, you would no doubt move on to another house where the owners had not overextended themselves on the mortgage. That's what any sensible burglar would do.

If you were a raccoon and had a taste for a large omelet, would you raid the pigeon coop or the hen house? Most raccoons I know would by-pass the pigeon roost and head straight for chicken city. Raccoons are smart.

If you were working an accident insurance scam, would you jump in front of a Mercedes or a 1960 VW van to stage your "injury"? I am sure even the most stupid scam artist would prefer to get bumped by the upper class German wheels.

In each case, the culprits were crafty enough to go right for the gold and not waste their time on low-return enterprises. Actually, it doesn't take too much intelligence to figure that out. The lawyers caught on right away about the bonanza called liability insurance. Ken Vinson, Professor of Law at Florida State University, wrote in the June 1986 issue of the *Palm Beach County Medical Society Bulletin*, "Never have our courtrooms been so full of litigators trying to soak some defendant — preferably a filthy rich corporation..." Later in the same article, "Pillars of Greed: A Lawyer's View," Vinson said, "Academy (of trial lawyers) legal eagles persuade juries to soak defendant doctors' liability insurance companies for millions." Much to Attorney Vinson's credit, he thought there had to be a better way — "if only bar groups and lawyer-ridden legislatures didn't stand in the way of legal reform."

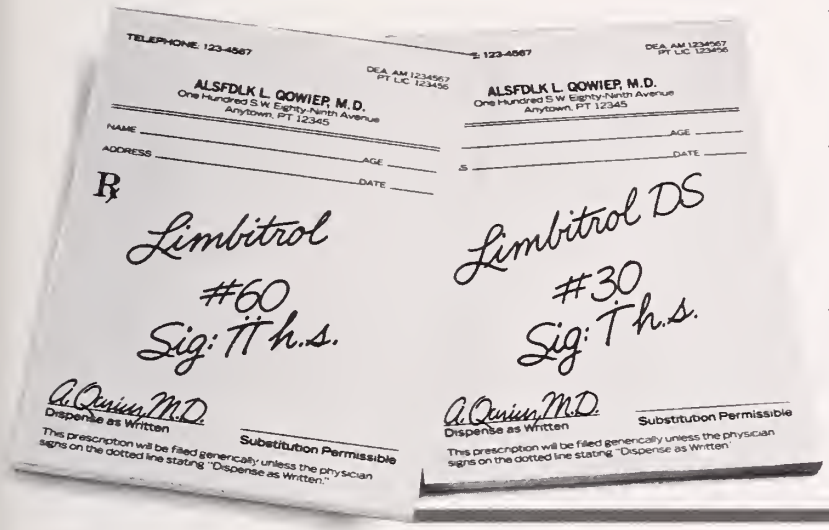
Physicians everywhere have been knocking themselves out to effect even the tiniest measure of tort reform. They have been forced to butt heads with people who actually enjoy violent verbal encounters, and they have pleaded for relief at the feet of Lady Justice only to discover that she ain't no lady. Perhaps we are on the wrong track. Let me share with you how Financial Programs, a family of mutual funds, decided to handle the problem of liability insurance for its directors. They also discovered that since 1984 "coverage obtainable has decreased significantly, despite no claims having been made, and the cost of coverage has more than tripled" (quoted from shareholder proxy statement, April 1988).

In 1987 the State of Colorado (home of Financial Programs) amended the Colorado Corporation Code to permit a corporation to include in its articles of incorporation a provision that would limit or eliminate a director's personal liability for monetary damages resulting from a breach of fiduciary duty of care. "The new law was prompted, in part, by the crisis in the directors' and officers' liability insurance market," continued the proxy statement, "and is intended to assist Colorado corporations to attract and retain qualified individuals to serve as directors."

To take advantage of this revised code for corporations, Financial Programs submitted such an amendment to its shareholders for approval in 1988. The board believed "that the Amendment will reduce the costs and risks to the Fund of unwarranted shareholder litigation, because monetary damages will not be as readily available to plaintiffs and their attorneys." That statement gets right to the heart of the problem, doesn't it? If you don't want greedy litigants and their lawyers dancing around a pot of gold, fill the pot with sand instead. However, according to the fund's legal department, the amendment did not pass because of shareholder apathy. Apathy is just as good as gold to the litigious troops who clog dance on the floors of businesses, hospitals and medical offices across this nation. Perhaps we need to throw a little more sand on the floor.

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓥ

Limbitrol® DS

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol® Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manufestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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In the depressed and anxious patient

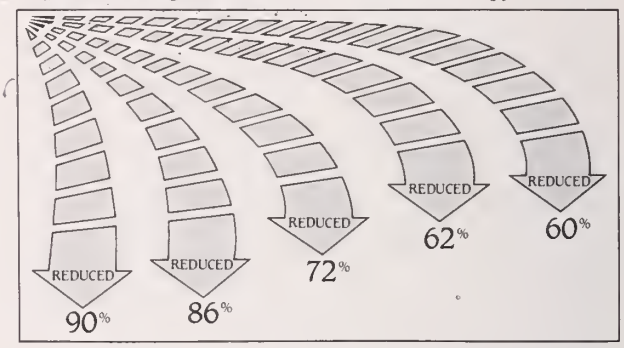
See Improvement In The First Week[1]...

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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Which Way To Go?

COVER

Recollecting Robert Frost's often-quoted poem that begins: "Two roads diverged into a wood..." may serve as apt description for this month's cover of *The Journal* which is devoted to the controversial *Harvard Resource-Based Relative Value Study.* In an attempt to unravel the issue, we are pleased to present several special articles on the study that offer some interesting prespectives and — with due respect to Mr. Frost — may make "all the difference".

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vicodin® (III)

(hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500 mg)

INDICATIONS AND USAGE: For the relief of moderate to moderately severe pain.
CONTRAINDICATIONS: Hypersensitivity to acetaminophen or hydrocodone.
WARNINGS:
Allergic-Type Reaction: VICODIN contains sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than non-asthmatic people.
Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on brain stem respiratory centers. Hydrocodone also affects centers that control respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. (see ADVERSE REACTIONS: Respiratory Depression).
Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.
PRECAUTIONS:
Special Risk Patients: As with any narcotic analgesic agent, VICODIN should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.
Information for Patients: VICODIN, like all narcotics, may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly.
Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN is used postoperatively and in patients with pulmonary disease.
Drug Interactions: Patients receiving other narcotic analgesics, antipsychotics, antianxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN may exhibit an additive CNS depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.
The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone.
The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.
Usage in Pregnancy: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nonteratogenic effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. The intensity of the syndrome does not always correlate with the duration of material opioid use or dose. There is no consensus on the best method of managing withdrawal. Chlorpromazine 0.7 to 1.0 mg/kg q6h, and paregoric 2 to 4 drops/kg q4h, have been used to treat withdrawal symptoms in infants. The duration of therapy is 4 to 28 days, with the dosage decreased as tolerated.
Labor and Delivery: As with all narcotics, administration of VICODIN to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.
Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS:
Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, dizziness, psychic dependence, mood changes.
Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. The antiemetic phenothiazines are useful in suppressing these effects; however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN may produce constipation.
Genitourinary System: Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.
Respiratory Depression: (See WARNINGS.)
DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. However, tolerance to hydrocodone can develop with continued use and the incidence of untoward effects is dose related.
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Blank space indicates that no such activity has been reported.

Table adapted from Facts and Comparisons (Nov.) 1984 and Catalano RB. The medical approach to management of pain caused by cancer. "Semin Oncol" 1975; 2; 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. "Ann Intern Med" 1980; 93; 588-96.

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1. Hopkinson JH III. *Curr Ther Res* 24: 503-516, 1978.
2. Beaver WT. *Arch Intern Med* 141: 283-300, 1981.

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EDITORIALS

Amendment 10: Some Afterthoughts

The failure of Amendment 10 to pass on November 8 effectively dimmed the lights for any immediate solution to the smoldering liability problem. And so we are back to another dead-end. The crisis for physicians, in the meantime, continues to boil over.

Beneath the rubble, physicians are still asking about what had happened. What appeared to be a certain victory two months ago turned into a bitter, almost inexplicable loss. What made the majority of voters turn against Amendment 10? How would this affect the current liability situation? And what options are left open for physicians?

Although most Floridians recognize the existence of a liability problem, particularly for physicians, the obnoxious campaign mounted by trial lawyers in linking Amendment 10 as a protection for drunken drivers, drug dealers, and toxic polluters effectively swayed many voters into opposing it. Early polls taken by the FMA showed that 69% of voters would support Amendment 10; shortly after the TV blitz by trial lawyers began, that support gradually crumbled. The FMA vigorously went on the offensive to explain the gut issues and to counter the lies and deception being spread by Alert 88, but a lot of people by then were confused. Amid this uncertainty, many who firmly supported the amendment vacillated and eventually turned the tables against it.

In the aftermath of the loss, a lot of voters were saying: Yes, we understand the problem and we support the cause of the physicians, but we did not clearly understand Amendment 10. That, in a nutshell, says it all. The trial lawyers, through a cleverly disguised campaign of protecting the constitutional rights of Floridians, succeeded in instilling fears and doubts into the minds and hearts of many voters, and then it was all over.

But the liability crisis is far from over. A month from now, many physicians will be getting renewals for their malpractice coverage and are certain to get further increases in their premiums. Many high-risk specialists already paying $100,000 or more per year may find it impossible to continue practicing. A likely scenario is that many more physicians will go bare, curtail their services, move elsewhere, or quit, while a number of hospitals will have to close their emergency rooms and their trauma centers. The situation in South Florida is a time bomb just waiting to explode. I hope that never happens but, if it does, the public should know who the culprits are.

What can physicians do now? With all the disappointments and losses that physicians have sustained in their fight for tort reforms the past 12 years, it is tempting to say to heck with it, give it up, and do nothing. That, unfortunately, will just compound the problem. There is still an urgent need for physicians to convey to the public that there is a festering liability problem and that it needs to be solved for physicians to continue serving their patients well. The acknowledged public recognition of this problem and the fact that over 46% of voters supported us should prod responsible citizens from both the private and public sectors to sit down together, review the issues and come up with solutions that are fair to everybody, but most of all to the public that we serve. The challenge is greater than ever for the legislature in Tallahassee to seize the initiative and take a hard, dispassionate look at the problem.

The defeat of Amendment 10 should not overshadow the heroic work and unbending dedication displayed by the FMA and its officers, its decision-makers, the Auxiliary and numerous other friends in fighting to reform the tort system. Even in a losing cause, all deserve our highest plaudits.

To the minority of FMA members who have decided, for whatever reason, not to pay their $500 assessment, this is a good opportunity to rethink their position and return to the fold. The FMA serves the interests of every physician, and breaking away from the ranks serves no purpose except to fragment the unity of the organization. Failing to comply with required financial obligations should not be used as a substitute for healthy dissent with the policies of the FMA.

The campaign for tort reform will not be the last battleground for physicians; there will be many more in the future. Amendment 10 taught us the lesson that we should be absolutely united and that we should work harder than ever to protect the interests of our patients.

R.G. Lacsamana, M.D.
Editor

Attracting the Best and Brightest Back Into Medicine

In my opinion the TV program, "L.A. Law" is compounding a real problem that has evolved in the United States. It is glorifying careers in nonscientific occupations. Experts in education predict that we will amass a deficit of 700,000 scientists and engineers within the next 20 years.

The shunning of science by so many bright students is being felt keenly in the admission offices of America's medical and nursing schools. There are almost 15,000 fewer applicants to medical school this year than there were in 1974. Schools of nursing are farther along this evolutionary trail than medical schools. Not only have many of the prospective nursing students opted to carry briefcases rather than stethoscopes, but the recent graduates have experienced an unprecedented failure rate (16% nationally this year) on the state board examinations. If the disturbing performance on state boards is any measure of the quality of current nursing students, then what does this portend for the quality of future medical students?

As far as the declining number of medical school applicants is concerned, there are many causative factors at work. Students seem to be saying the time, effort and expense involved in becoming a doctor are just not worth it. Not only that, but the tarnished image of doctors and medicine in general, the escalating interference of third parties in the physician-patient relationship, the constant threat of lawsuits with their attendant stresses, both emotional and financial, and the bleak outlook for the survival of private practice make other fields look much more attractive than medicine. And that is really too bad, because it heralds the movement toward mediocrity in medicine.

I think astute students are drawing some significant conclusions from the fact that the public expresses so little sympathy for the plight of today's beleaguered physicians. They can sense the increasing willingness of insurance-premium and doctor-bill whipped consumers to take their chances with any form of medical-care delivery they perceive to be more accessible, more convenient, and less expensive. This concept is so attractive to so many patients that even a little compromise in quality to attain it becomes an acceptable risk.

No, "L.A. Law" is not a cause of the exodus of students from the halls of science and medicine. It is merely a reflection of attitudes in our society toward the way things are. Things got the way they are because we let them and, more significantly, because we contributed to them. To effect change we, as individual physicians and as a profession, must change. To attract top students to the field of medicine we must do everything we can to make it worth their time and effort. We must make medical care more accessible, more convenient, more compassionate, and more affordable. That is the only way private medicine will survive. Only then can we expect the best among our youth to be called to medicine.

Dale C. Havre, M.D.
Inverness

Is Tort Reform Really the Answer?

For anybody who has been associated with medical practice more than a few years it is redundant to point out that changes have occurred and continue to occur. Further, if one has spent most of his life in the profession, the changes have been sufficient to render the present practice scene unrecognizable as an evolutionary, developmental product of what once was. But, of course, it is not an evolutionary product. It is rather, as though, through outside influences, the old was melted down, recast, and a new model made, the old material being barely recognizable in the new form.

About ten years ago, in response to the changing times, I found myself pondering the question of

whether or not medicine was still a profession and, if it were, could it long remain so. A scan of the literature at that time revealed a fairly general consensus as to the characteristics possessed by a profession in order to be considered as such. Some might present a more extensive list or might phrase the characteristics a little differently and perhaps give them different weights, but I believe the following are the essentials.

- A defined body of knowledge requiring advanced study.
- Autonomous certification by peers following completion of study and demonstration of proficiency.
- Voluntary acceptance of an oath or vow to adhere to a prescribed code of conduct in associations with patients, colleagues, and society.
- Internal discipline for failure to adhere to the code.
- An expected standard of behavior and a degree of self-sacrifice not required of others.

If these describe a profession, are we still a profession? There is no question that there is still a defined body of knowledge that requires advanced study but it has become so vast that compartmentalization has become necessary. A grasp of the entire subject defies the capabilities of anyone save the superhuman, and a person learned in one compartment may have no kinship with one equally learned in another. Where is the unity? Where is the autonomy? Certification authority has been preempted by legal considerations, and the oath, which once prescribed an almost priestly code of conduct, has been watered down to a point of little meaning. Even had it not been, infractions occur with impunity because of the legal impediments to discipline. As far as exemplary conduct is concerned, feet of clay are too often clearly revealed and while doctors do sacrifice a great deal because of the long and irregular hours demanded of them, they are well paid in return.

If not a profession, then what?

Many years ago, with little experience to call upon, I was being coached by an attorney in preparation for testimony I was to give in a personal injury case. One point was especially stressed. I was cautioned to avoid a trap which would almost certainly be set. Attorneys at that time were fond of asking a doctor if medicine was a precise science. The natural instinct was to defensively assert that it certainly was. However, as we pointed out then, and as maturity has reinforced, the practice of medicine is a balanced mixture of art and science, with the science being very imprecise, dealing as it does with persons of independent wills and unpredictable chemical and hormonal responses. However, the increasingly amazing technological discoveries have weighted the equation toward the scientific end. And now, commercialization and marketing to a public eager to purchase, from providers anxious to sell and the product takes on the luster of an exact science.

With the proper product or procedure, every ailment and malaise will disappear. Death can be forestalled until sometime, remote in the future, when one would not wish to go on living anyway. Some are preaching suspended animation, secure in their belief that continued scientific discoveries will permit reincarnation to be carried out. Perhaps this could all be excused as exuberant salesmanship based on a degree of success. The public, our patients, has been sold but it saddens me to sense that we, the doctors, have also been convinced by our own sales pitches.

The art, to a very large degree, has been removed from medical practice. We are providers of a commercial product and as such are subject to product liability concerns. Insuring against losses due to litigation regarding real or fancied damages becomes one of the costs of doing business and must be factored into the price of the product. I have seen nothing in tort reform proposals that convince me such litigation will be reduced, although the awards may be. Liability insurance will continue to be a significant item in business overhead.

Is this all there is to look forward to? I don't know, but I can see some possible scenarios. Medical care may become so costly as to be priced out of the marketplace. As a result, society may find that it can get along quite nicely with less of the science. Or society may decide that it wants more and be willing to sacrifice in other areas of the public good in order to pay for it. Or, and I personally believe that this is most likely, society may come to the realization that promises have limits and expectations must be realistic. Individuals will recognize their mortality and doctors' fallibility. They will seek to satisfy their hunger for a more artful type of medical treatment. As a result, there may well be a rebirth of the profession by separation of its practitioners from their highly trained counterparts, the business-oriented technocrats. Such a reorientation would do more to solve the PLI puzzle than any amount of tort manipulation. It wouldn't do much to relieve the cost of doing business for the medical technicians but it would bring their services into better perspective and might solve a lot of other medical/social problems. Practicing medicine might be fun again.

James K. Conn, M.D.
Tallahassee

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Private and Public Sectors Form Partnership to Solve Indigent Maternity Care Crisis

Increasing malpractice rates, budget constraints, and increasing demand for obstetrical services to low-income maternity patients have caused a maternity care crisis throughout the State of Florida and the United States.

Seminole County, located in central Florida, is no exception. Approximately 3,000 resident deliveries are recorded annually from a population of 267,000. A large number of these patients meet indigency criteria. Compared to the private sector, the lower governmental payments for indigent care forced private obstetricians and hospitals to reevaluate the economic feasibility of participating in obstetrical care for indigent patients.

Seven obstetricians were on staff at Central Florida Regional Hospital in 1986, the only hospital with an OB unit at that time. By April 1987 three had terminated their privileges and three had submitted written letters of intent to discontinue obstetrical privileges and services by May 15, 1987. James D. Tesar, hospital administrator, stated that "Central Florida Regional Hospital will be forced to close its OB unit since it is not possible for one physician, however willing, to provide continuous OB services."

In an atmosphere of trust, which has been established over the last few years, several meetings between county health department staff, obstetricians, hospital staff and county commissioners resulted in a short-term resolution which caused three obstetricians to withdraw their resignation and to continue privileges and service at the hospital. The intent of all parties was to continue and improve obstetrical services for residents of Seminole County. This action would ensure continuation of the downward trend of infant mortality which has been reduced from 15.1 per 1,000 live births in 1978 to 6.7/1,000 live births in 1987. This trend represents dozens of infant lives saved. The short-term solution included funding commitments of $60,000 each from Central Florida Regional Hospital and Seminole County Board of County Commissioners to hire nurse midwives, and additional funding to support slightly expanded reimbursement rates to obstetricians until Medicaid rates were expanded. The combined funding would support three nurse-midwives who would practice at the Hospital under physician supervision and work at the health department in prenatal clinics. No nurse midwives could be hired due to a shortage of certified professionals.

In June 1987 Florida Hospital/Altamonte began obstetrical service in Seminole County and offered to deliver 12 to 15 county indigent patients per month. This additional resource was welcomed by the obstetrical community; however, it was quickly overwhelmed by the effect of the Indigent Health Care Act passed by the 1987 State Legislature. Expanded eligibility criteria and presumptive eligibility greatly increased the indigent population; requests for care doubled.

As resources were stretched to the limit, boundary issues emerged between hospitals, preregistration for clients was fused, cesarian section deliveries were performed subsequent to labor, and serious liability issues emerged.

A series of several meetings commenced in November 1987 which resulted in a unique and true partnership between the private and public sector. On August 23, 1988, the Maternity Care Agreement was signed by the Chairman of the Board of County Commissioners, Fred W. Streetman Jr., the two hospital administrators and the two chairmen of the respective hospital Department of Obstetrics. Since that time the signature of all 11 obstetricians practicing in Seminole County have been secured.

This unique agreement in summary involved the following ingredients:

1. All Medicaid and low-income eligibility determination will be completed at the Seminole County Health Unit.
2. Prenatal care will be provided at Seminole County Public Health Unit until patient is Medicaid-eligible and/or reaches 20 weeks gestation; whichever comes later.
3. Referrals to private obstetricians will be accomplished on a rotating basis for the second half of the pregnancy. These patients will be seen and cared for by the obstetricians and delivered by them, as they do with their private patients.
4. Bylaws of participating hospitals have been amended to require physicians to participate in rotation.
5. The Health Department or County Health Unit will do all the Medicaid billing on behalf of the obstetricians in order to relieve them of this chore.
6. Central Florida Regional Hospital will fund $81,000 of the proposal.

7. Florida Hospital/Altamonte will fund $30,000 of the proposal.
8. The Board of County Commissioners will fund the proposal in an amount up to $285,000 per year.
9. No boundaries of hospital responsibility will be imposed; however, the program coordinator will make every effort to see that patients are assigned to physicians and hospitals which are reasonably accessible.

This program became effective October 1 and we are extremely hopeful of the successful implementation of this unique partnership between the private and public sector. Goodwill, trust and a sense of public commitment to improve maternity services were the driving forces in making possible this agreement.

Jorge Deju, M.D., M.P.H.
Director
Seminole County Health Unit, Sanford

Thoughts on Hemochromatosis

Several studies have demonstrated that the prevalence of hemochromatosis in the Caucasian population is one in 400, making it one of the most common autosomal recessive conditions.[1-3] The same figure has been found in studies performed in Utah, Brittany and Scotland. Ascertainment of affected individuals was by liver biopsy, transferrin saturation, or at autopsy.

To investigate the possibility of undetected hemochromatosis at Shands Hospital and the University of Florida Clinics, we surveyed the patients who had iron profiles performed in the clinical chemistry laboratory between July and September 1987. Results were available through the computer system for 39 patients. Most of the patients had iron profiles performed for evaluation of possible iron deficiency. Of these 39, five had elevated serum iron concentrations; one was already followed by the hematologist for hemochromatosis. One had deliberately taken an iron overdose. One patient had liver failure but the biopsy was negative for hemochromatosis. Limited information was available on another patient who was being followed by an obstetrician. The fifth patient had a congestive cardiomyopathy of unknown etiology. We advised the attending cardiologist about the possibility of hemochromatosis.

Hemochromatosis needs to be considered in any patient who has hepatic dysfunction, cardiomyopathy, diabetes, or unexplained arthritis, early menopause or impotence. In addition, the finding of elevated serum iron, ferritin or transferring saturation in any patient needs to be taken seriously. If these are found, the definitive diagnosis is made by liver biopsy.

As noted, the inheritance for hemochromatosis is autosomal recessive. If an individual is found to be homozygous for hemochromatosis, the likelihood that a sibling is affected is 25% and the likelihood that a child or parent is affected is 2.5%; therefore, screening by measurement of serum iron, ferritin and transferrin saturation should be offered to all first degree relatives.

References

1. MacSween, R.N.M. and Scott, A.R.: Hepatic Cirrhosis: Clinicopathologis Review of 520 Cases, J. Clin. Path. 26:936, 1972.
2. Beaumont, C.M.; Simon, M.; Fauchet, R., et al: Serum Ferritin as Possible Marker for Hemochromatosis Allele, N. Engl. J. Med. 301:169, 1979.
3. Cartwright, C.E.; Edwards, C.Q.; Kravitz, K., et al: Hereditary Hemochromatosis. Phenotypic Expression of Disease, N. Engl. J. Med. 301:175, 1979.

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Need for Geriatric Education Urgent in Florida

The nation's elderly population in both absolute numbers and percentage has steadily increased so that 11.9% of Americans in 1985 were 65 years old or older (Table 1). Florida, with 17.6% of is population over age 65, has proportionately many more elderly residents than any other state (Table 2). Only California and New York, because of their large populations, exceed Florida; nonetheless, the percentage of elderly in these states is appreciably lower than in Florida (Table 3). Therefore, Florida with 2 million elderly residents, representing by far the largest percentage of elderly (17.6%) in any state, finds itself demographically in advance of all other states in confronting the special needs of the elderly.

Table 1.—U.S. Population.[3]

Year	Total Population	Elderly (65+ Years)	Percent Elderly
1960	180,671,000	16,675,000	9.2
1970	205,052,000	20,107,000	9.8
1980	227,757,000	25,704,000	11.3
1985	239,283,000	28,530,000	11.9

Table 2.—States with Elderly (65+ Years) Population Over 13% in 1985 in Descending Order of Population.[3]

State	Total Population	Elderly (65+ Years)	Percent Elderly
Florida	11,366,000	2,001,000	17.6
Rhode Island	968,000	139,000	14.4
Pennsylvania	11,853,000	1,698,000	14.3
Iowa	2,884,000	413,000	14.3
Arkansas	2,359,000	338,000	14.3
Missouri	5,029,000	687,000	13.7
South Dakota	708,000	97,000	13.7
Nebraska	1,606,000	217,000	13.5
Massachusetts	5,822,000	783,000	13.4
Kansas	2,450,000	326,000	13.3
West Virginia	1,936,000	257,000	13.3
Oregon	2,687,000	354,000	13.2
Maine	1,164,000	153,000	13.2
Connecticut	3,174,000	413,000	13.0

Health problems are the major concern of Florida's elderly as identified by a poll conducted by the Florida Aging Program Office.[1] The elderly population places great demands on practitioners from all health care disciplines. Appropriate care requires that health professionals have geriatric training. As the National Institute on Aging reports, "Essentially all health and human services personnel should be educated specifically about the special conditions and needs of older persons and have up-to-date knowledge concerning the most effective means of preventing and managing diseases and disabilities experienced by older adults."[2]

The 1985 Report of the Florida Committee on Aging[1] pointed out that the vast majority of practicing health care professionals have had no formal training in geriatric care. To rectify this the Committee recommended: (a) faculty recruitment and curriculum development to provide basic and continuing education to health care professionals; (b) development of a roster of health care professionals with geriatric and gerontologic expertise to serve as an educational resource; (c) provision of geriatric-oriented courses in the education of health professionals; and (d) inclusion of geriatric patient care experiences in postgraduate professional training program.

The key in education. This has been recognized by the federal government, too. In 1983 the Health Resources and Services Administration, Bureau of Health Professions, funded four Geriatric Education Centers. These have grown to 33 with the purpose of providing geriatric education to health professions faculty. The ultimate goal is to improve the health care of the elderly.

In 1987 two Centers were funded in Florida: at the University of Florida and University of South Florida. These centers are working together to improve geriatric knowledge and skills. Virtually all health care disciplines are targeted. (Table 4).

The University of Florida Geriatric Education Center (UF-GEC) and the University of South Florida Geriatric Education Center (USF-GEC) have several major objectives in concert with federal program guidelines. First, the primary purpose is to develop educational programs to train health professions faculty. Faculty members will return to their home institutions to establish or expand geriatric education programs. In this way the supply of health professions faculty with geriatric skills and knowledge will be increased.

A second aim is to provide geriatric continuing education programs for health care professionals. These programs will stress a multidisciplinary approach to care. Included will be inservice programs for nursing home personnel.

Third, geriatric curricula will be developed for students and for practicing health care professionals. Curricular material will be made available in the state and nationally.

The fourth aim is to provide consultation and technical assistance to organizations, institutions, professional associations, and state, local and voluntary agencies to assist them in developing, implementing, and evaluating new geriatric educational offerings.

Objective five is to establish a resource center for geriatric educational material to include books, pamphlets, curricula, syllabi, films and videotapes. This material will serve as a resource for consultations and will be made available for use by other institutions.

Table 3.—States with an Elderly (65+ Years) Population of Two Million or More in 1985.[3]

State	Total Population	Elderly (65+ Years)	Percent Elderly
California	26,365,000	2,766,000	10.5
New York	17,783,000	2,254,000	12.7
Florida	11,366,000	2,001,000	17.6

Table 4.—Health Care Disciplines Targeted by Geriatric Education Centers in Florida.

University of Florida	University of South Florida
Medicine	Medicine
Dentistry	Nursing
Nursing	Podiatry
Pharmacy	Pharmacy
Clinical Psychology	Gerontology
Physician Assistants	Social Work
Physical Therapy	Clinical Psychology
Occupational Therapy	
Speech Pathology and Audiology	
Dietetics	

The resource center will allow for ease of access to geriatric educational material by those conducting geriatric educational programs in the state.

The last aim is to publicize information about geriatric education programs, services, and materials. Newsletters will contain announcements of courses and conferences throughout the state.

The UF-GEC has targeted Florida as its impact area. The USF-GEC has regionalized its impact area to the gulf coast of central and south Florida and inland to Orlando. The density of elderly population on the west coast merits "double coverage" and offers the opportunity for a collaborative training project between the USF-GEC and the UF-GEC.

Eduction and training in gerontology and geriatrics has existed for many years at the University of South Florida and the University of Florida. The heightened need for more adequately trained faculty and practitioners is reflected in the 60% increase in ambulatory care visits to physicians of persons aged 75 and over in the last ten years.[2] The ability of these two universities to respond to the educational need is enhanced through the support provided to each via their Geriatric Education Centers. The two Centers are devising ways to collaborate on projects and to utilize the special areas of expertise each possess to further improve the health care of older people in Florida.

References

1. Pathways to the Future. Report of Florida Committee on Aging, January, 1985, Tallahassee.
2. Personnel for Health Needs of Elderly Through the Year 2020. September, 1987, National Institute on Aging, National Institutes of Health, Report to Congress, U.S. Government Printing Office (1988-201-597/82551) Washington, D.C.
3. National Data Book and Guide to Services. Statistical Abstract of the U.S.: 1987, 107th Edition, Washington, D.C.

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Many Thanks

I would like to take this opportunity to thank all the physicians who helped me with contributions and encouragement during my recent campaign for Florida House District 19. We lost the run-off by 153 votes, 52% to 48%, on October 4th. The trial lawyers helped my opponent to raise $17,000 in the last 10 days before the election.

I would like to tell everyone that the old tale that doctors don't contribute to political campaigns is *not* true. About 500 physicians contributed more than half of approximately $75,000 that it cost my campaign to run for this house seat, and without them there wouldn't have been much of a campaign. Most impressive was the encouragement and moral support that I received from the Florida Medical Association and its staff. We came close. We made an impact. Thank you all who contributed, who worked, who helped and who voted.

James H. Corwin, M.D.
Jacksonville Beach

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea), 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever), 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
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1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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Correlation of Hormone Receptors with Histologic Differentiation in Ovarian Carcinoma

Blake R. Nestok, M.D., Shahla Masood, M.D., and Nancy Lammert, M.D.

ABSTRACT: ***Fifty epithelial ovarian tumors were analyzed for hormone receptor content (estrogen and progesterone) and the quantitative values were compared with several histologic characteristics by which ovarian tumors are usually graded (nuclear and cell size, nucleoli, mitotic activity, necrosis and growth pattern) and two other features, tissue response and vascularity. Specimens with a high degree of tissue response (fibrosis and/or inflammatory reaction) had a significantly greater probability (P=0.03) of being progesterone receptor negative than specimens with less tissue response.***

Tumors with a solid growth pattern had a significantly (P=0.008) greater chance of being progesterone receptor negative than those with a papillary or mixed pattern of growth. The estrogen and progesterone receptor content of epithelial ovarian tumors appears to be independent of the other histologic characteristics studied.

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The occurrence of estrogen and progesterone receptors in ovarian carcinomas is well established and has resulted in numerous investigations regarding the prognostic significance of these determinations.[1-12] Thus far, steroid receptor content of ovarian carcinomas has not been demonstrated to correlate well with histologic differentiation, a known predictor of biologic aggressiveness. In some studies, however, hormone receptor content appears to be independently predictive of response to therapy so that the clinical utility is justified regardless of lack of correlation.[1-3] Reported herein is a study of 50 cases of ovarian carcinomas which have been assayed for estrogen and progesterone content and a comparison of the quantitative results to histologic parameters.

Methods • A retrospective study of 50 cases of primary and metastatic epithelial ovarian neoplasms was performed by examining histologic sections received by the Department of Pathology at University Hospital during a three year period. The grading process was performed jointly by us. The histologic differentiation includes 30 primary and 20 metastatic tumors. Of the primary tumors, seven were serous, nine mucinous, five endometrioid, eight adenocarcinoma (not otherwise specified), and one granulosa cell. The metastatic category included three serous, one mucinous and 16 adenocarcinoma (not otherwise specified).

The cases were graded for cell size (1-5+), nuclear size (1-5+), hyperchromasia (cleared, diffuse or clumped), mitoses (1-3+), necrosis (1-3+), tissue response (1-3+), vascularity (1-3+) and pattern (1-3+).

For cell size, a grade of 1+ corresponds to the size of a lymphocyte, 2+ corresponds to two times the size of a lymphocyte, and so on, up to 5+ which is greater than four times the size of a lymphocyte. Nuclear size was graded similarly with 1+ being one half the size

of a lymphocyte, and 5+ being greater than 2.5 times the size of a lymphocyte. Nucleoli were evaluated using a scale of 1+ for inconspicuous, 2+ for conspicuous, and 3+ for multiple. Mitoses were enumerated using 1+ as none to few, 2+ as one per high power field, and 3+ as greater than one per high power field. Necrosis was graded using 1+ as none to 10%, 2+ as 10-25%, and 3+ as greater than 25%. Tissue response was graded from 1+ (none) to 3+ (abundant), and vascularity from 1+ (mild) to 3+ (abundant). Growth pattern was classified as 1+ for papillary, 2+ for mixed and 3+ solid pattern. The results were statistically analyzed and with the use of a 2x2 contingency table and chi-square test, p-values were obtained.

At the time of surgery, a 1 cm^3 portion of each tumor was frozen at −20°C and shipped to Smith-Kline Bio-Science Laboratories where the quantitative estrogen and progesterone receptor assays were performed. The reagents used are provided by RIANEN™ [3H] estrogen and progesterone assay kit which is an adaption of current methodology for multiple point dextran-coated charcoal separation assays.[13,14]

Table 1.—Frequency Distribution of Histologic Features.

Histologic Feature	Frequency Distribution				
	1+	2+	3+	4+	5+
Cell Size	0	11(22)	19(38)	14(28)	6(12)
Nuclear Size	1 (2)	16(32)	18(36)	11(22)	4(8)
Nucleoli	16(32)	20(40)	14(28)		
Mitoses	17(34)	11(22)	22(44)		
Necrosis	29(58)	10(20)	11(22)		
Tissue Response	21(42)	20(40)	9(18)		
Vascularity	36(72)	7(14)	7(14)		
Pattern	22(44)	11(22)	17(34)		

Results ● The patients' ages ranged from 25 to 91 years with a mean of 58 years. Frequency distribution of histologic features that were analyzed is shown in Table 1. The mean estrogen receptor value for the 50 samples analyzed was 19.25 fmol/mg cytosol protein (SD ± 23.0, range 0 to 97, median 13.5). Fifteen samples (30%) contained less than 3 fmol/mg cytosol protein and were considered to be negative, eight (16%) contained 3-9.9 fmol/mg cytosol protein and were considered borderline, and 27 (54%) contained greater than 10 fmol/mg cytosol protein and were considered to be positive for estrogen receptor content. The mean progesterone receptor level for the 50 samples was 103.0 fmol/mg cytosol protein (SD ± 318.1, range 0 to 1913, median 4.1). Twenty-four samples (48%) contained less than 3 fmol/mg cytosol protein of progesterone receptor and were considered to be negative for progesterone receptor, two (4%) contained 3 to 9.9 fmol/mg cytosol protein and were considered to be borderline, and 24 (48%) contained greater than 10 fmol/mg cytosol protein and were considered to be progesterone receptor positive.

A statistically significant association was observed between progesterone receptor content and tissue response and cellular pattern. Tumors with a higher degree of tissue response-fibrosis and inflammatory reaction (2+ and 3+) had a statistically significant greater likelihood of containing low levels of progesterone receptor (P=0.03). Twenty eight (56%) of the cases examined had increased tissue response (Table 2).

Table 2.—Tissue Response Versus Progestin Receptor Content.

	Progestin Receptor Content						
	Negative (<3 fmol)		Borderline (3-9.9 fmol)		Positive (>10 fmol)		Total
	N	%	N	%	N	%	N(100%)
Tissue Response							
1+	9	41	0	0	13	59	22
2+	7	37	3	16	9	47	19
3+	8	89	0	0	1	11	9
TOTAL	24		3		23		50
P=0.03							

Tumors with a solid growth pattern had a significantly increased chance of containing low levels of progestin receptors (P=0.008). Seventeen (34%) of the cases examined displayed a solid growth pattern (3+). Eleven (22%) had a mixed pattern (2+) and 22 (44%) had a papillary growth pattern (Table 3).

Table 3.—Growth Pattern Versus Progestin Receptor Content.

	Progestin Receptor Content						
	Negative (<3 fmol)		Borderline (3-9.9 fmol)		Positive (>10 fmol)		Total
	N	%	N	%	N	%	N(100%)
Tissue Response							
1+	7	32	1	4	14	64	22
2+	6	55	1	9	4	36	11
3+	11	65	1	6	5	29	17
TOTAL	24		3		23		50
P=0.008							

The estrogen receptor content of the cases assayed failed to show a statistically significant correlation with the histologic parameters examined.

Discussion ● The study supports the findings of Schwartz et al that the estrogen and progestin receptor content of ovarian carcinomas is independent of routine histologic features.[4] The two exceptions in the present study are the relationship between progestin receptor content versus tissue response and growth pattern. Cancers with more extensive tissue response had a significantly greater probability of being progestin receptor negative, and tumors with a

solid growth pattern had a significantly greater chance of being progesterone receptor negative.

Several studies have shown that histologically well differentiated breast cancers are more likely to be estrogen and progesterone positive.[15-17] However, breast cancers negative for hormone receptors have also responded to hormonal manipulation.[1] It has been suggested that factors such as desmoplastic responses or necrosis will result in false-negative biochemical determination for receptor content.[4] Indeed, in the present study, increased tissue response including inflammation, necrosis and desmoplasia was found to correlate with low progesterone receptor content. As Schwartz et al[4] have noted, some reports suggest that well differentiated ovarian carcinomas are more likely to contain estrogen receptors but in another report the reverse was reported.[1,2,5-8] Furthermore, one study shows the absence of correlation between hormone receptor content and histologic grade of ovarian carcinomas.[9] Several explanations for the discrepancies have been proposed such as difference in assay techniques, cut off values for receptor positivity and tumor heterogeneity. In endometrial carcinomas, Young[18] has suggested that "cut off" values could be manipulated to more closely correlate with clinical responses of tumors to normal manipulations.

Considering the conflicting reports in the literature thus far, applications to clinical situations should be approached with caution. Data from this study, however, lend support to the concept that sex steroid hormone receptor content of ovarian carcinomas is independent of histologic differentiation. Further investigation of more objective parameters utilizing flow cytometry and image analysis is being conducted here and at other centers providing further insight into the biologic behavior of these neoplasms.

Acknowledgment

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References

1. Schwartz, P.E.; LiVolsi, VA, Hildreth, N., et al: Estrogen Receptors in Ovarian Epithelial Carcinoma, Obstet. Gynecol. 59:229-238, 1982.
2. Kauppila, A.; Vierikko, P., Kivinen, S., et al: Clinical Significance of Estrogen and Progestin Receptors in Ovarian Cancer, Obstet. Gynecol. 61:320-326, 1983.
3. Schwartz, P.E.; Keating, G.; MacLusky, N., et al: Tamoxifen Therapy for Advanced Ovarian Cancer, Obstet. Gynecol. 59:583-588, 1982.
4. Schwartz, P.E.; Merino, M.J.; LiVolsi, V.A., et al: Histologic Correlations of Estrogen and Progestin Receptor Protein in Epithelial Ovarian Carcinomas, Obstet. Gynecol. 66:428-433,1985.
5. Janne, O.; Kauppila, A.; Syrjala, P., et al: Comparison of Cytosol Estrogen and Progestin Receptor Status in Malignant and Benign Tumors and Tumor-Like Lesions of Human Ovary, Int. J. Cancer. 25:175-179, 1980.
6. Hahnel, R.; Kelsall, G.R.H.; Martin, J.D., et al: Estrogen and Progesterone Receptors in Tumors of Human Ovary, Gynecol. Oncol. 13:145-151, 1982.
7. Quinn, M.A.; Pearce, P.; Rome, R., et al: Cytoplasmic Steroid Receptors in Ovarian Tumors, Br. J. Obstet. Gynecol. 89:754-759, 1982.
8. Ford, L.C.; Berek, J.S.; LaGasse, L.D., et al: Estrogen and Progesterone Receptors in Ovarian Neoplasms, Gynecol. Oncol. 15:299-304, 1983.
9. Creasman, W.T.; Sasso, R.A.; Weed, J.C., et al: Ovarian Carcinoma: Histologic and Clinical Correlation of Cytoplasmic Estrogen and Progesterone Binding, Gynecol. Oncol. 12:319-327, 1981.
10. Galli, M.C.; DeGiovanni, C.; Nicolette, G., et al: Occurrence of Multiple Steroid Hormone Receptors in Disease-Free and Neoplastic Human Ovary, Cancer 47:1297-1302, 1981.
11. Hamilton, T.C.; Davies, P., and Griffith, K.: Androgen and Oestrogen Binding in Cytosols of Human Ovarian Tumors, J. Endocr. 90:421-431, 1981.
12. Holt, J.A.; Caputo, T.A.; Kelly, K.M., et al: Estrogen and Progestin Binding in Cytosols of Ovarian Adenocarcinomas, Obstet. Gynecol. 53:50-58, 1979.
13. McGuire, W.L.; Carbone, P.O., and Vollmer, E.P. (eds): Estrogen Receptors in Human Breast Cancer, Raven Press, New York, 1975.
14. Raynaud, J.P. in Progresterone Receptors in Normal and Neoplastic Tissues, McGuire, M.L.; Raynaud, J.P., and Baulien, E.E., (eds): Raven Press, New York, 9-21, 1977
15. McCarthy Jr., K.S.; Barton, T.K.; Fetter, B.F., et al: Correlation of Estrogen and Progesterone Receptors with Histologic Differentiation in Mammary Carcinoma, Cancer 46:2851-2858, 1980.
16. Mills, R.R.: correlation of Hormone Receptors with Pathological Features in Human Breast Cancer, Cancer 46:2869-2871, 1980.
17. King, J.G.B.: Analysis of Estradiol and Progesterone Receptors in Early and Advanced Breast Tumors, Cancer 46:2818-2821, 1980.
18. Young, P.C.M.; Ehrlich, C.E., and Cleary, R.E.: Progesterone Binding in Human Endometrial Carcinomas, Am. J. Obstet. Gynecol. 125:353-360, 1976.

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Guidelines for Medical Management of Sickle Cell Disease

Charles H. Pegelow, M.D., Paul Pitel, M.D., and Jan Judisch, M.D.

ABSTRACT: Children with any of the variants of sickle cell disease, but particularly those with sickle cell anemia, have frequent, severe complications. Morbidity and mortality can be decreased by medical supervision and preventive care designed specifically for their problems. When complications occur, they must be diagnosed and treated promptly. Of greatest importance are bacterial sepsis, aplastic episodes, splenic sequestration, priapism and stroke. Delayed or inappropriate treatment can lead to severe morbidity or death. Transfusion is frequently considered as part of treatment and indications are discussed and guidelines given for its implementation.

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Diagnosis of sickle cell disease in the newborn period is valuable since it allows the provision of preventive health care designed to minimize or avoid certain of the expected complications. In addition, parents can be taught to identify developing problems and advised to obtain evaluation and treatment at the earliest possible time.

An outline for preventive care follows which incorporates principles valuable for children with sickle cell disease into the standard pediatric regimen. In addition, there are management suggestions for the most commonly encountered complications. Although extensive, they do not include all possible complications and will not be applicable in all situations. In general, careful adherence to good standards of medical care is sufficient for most problems. When unusual circumstances arise, telephone advice is available from the pediatric hematologists at any of the Childrens Medical Services Hematology Centers (Table 1).

Well child care ● Preventive health care should begin at two months as it would for hematologically normal children (Table 2). Complete blood counts with reticulocyte counts should be included at each visit to allow determination of baseline values. A leukocyte differential count is important since many children have high levels of nucleated red cells which will result in a spuriously elevated leukocyte count when done on automated cell counters. The leukocyte count and differential during times of good health are valuable since baseline values are frequently elevated in affected children making difficult their evaluation at the time of illness.

The problems encountered by children with sickle cell disease should be discussed with the parents at each visit. They should be taught what steps to take when complications arise; the most important is when to

Table 1.—Regional Childrens Medical Services Hematology Centers with Name of Responsible Pediatric Hematologists and Their Telephone Number.

CENTER	DAYTIME NUMBER	AFTER HOURS NUMBER
University of Florida Gainesville Samuel Gross, M.D. John Graham-Pole, M.D. William Cassano, M.D. Amos Kedar, M.D. Paulette Mehta, M.D.	904/392-5619	904/392-3331
University of Miami Miami Charles Pegelow, M.D. Susan Light, M.D. Stuart Toledano, M.D.	305/549-7752	305/549-7320
University of South Florida Tampa Eva Hvizsdala, M.D. Jaime Estrada, M.D.	813/972-8430	813/972-8430
University Hospital of Jacksonville Jacksonville Paul Pitel, M.D.	904/632-3902	904/350-6899
All Children's Hospital St. Petersburg Jerry Barbosa, M.D.	813/892-4176	813/898-7451
Orlando Regional Medical Center Orlando Vincent Giusti, M.D.	305/237-6320	305/841-7920
Sacred Heart Hospital Pensacola Tom Jenkins, M.D.	904/478-1100	904/478-1100

bring the child to medical attention.

By four months of age, penicillin prophylaxis should be started for all children who have the FS pattern on hemoglobin electrophoresis. This practice has been demonstrated to be valuable in reducing the frequency of *Streptococcus pneumoniae* bacteremia and should reduce the associated high mortality rate.[1]

Penicillin should be given at a dose of 125 mg twice daily until age three after which the dose is increased to 250 mg twice daily. Tablets are preferable to liquid preparations. They can be crushed and mixed with foods, a practice which seems to be easily accomplished.

The use of benzathine penicillin for prophylaxis was evaluated in Jamaica.[2] The study was terminated when significant compliance problems were encountered due to the discomfort caused by the intramuscular injections given at three week intervals. Although *fewer* infections were encountered in those children receiving this form of penicillin, the difference was not significant.

Penicillin prophylaxis has not been evaluated for children with Hemoglobin SC disease. However, the recent finding that their incidence of bacteremia during the first two years of life is similar to that of children who have sickle cell anemia[3] has caused some physicians to recommend it for these children as well. In fact, some hematologists suggest prophylaxis for all variants of sickle cell disease.

At 18 months, conjugated *Haemophilus influenzae* vaccine should be given as suggested in guidelines from the American Academy of Pediatrics.[4] This is followed at 24 months by polyvalent pneumococcal polysaccharide vaccine.[5] Booster doses of the latter preparation have been suggested by some investigators and have been administered with no reported complication.[6] However one of the manufacturers of the current 23 valent product has suggested that reimmunization not be attempted in any subject previously immunized with a polyvalent vaccine. This caution is presumably based on the possibility that a severe arthus type of reaction might occur. In the absence of clear guidelines, the decision to reimmunize must be individualized and if believed appropriate, undertaken with caution.

Unfortunately, use of these approaches do not ensure freedom from infection with *Streptococcus*

Table 2.—Minimal Routine Health Care Guidelines for Children with Sickle Cell Anemia and Hemoglobin SC Disease.

2 months
1. Routine child health care
2. DPT/OPV
3. CBC
4. Discuss with family: genetics, medical complications such as, infections, aplastic crisis, splenic sequestration, pain, especially hand-foot syndrome, and the importance of preventative health care

4 months
1. Routine child health care
2. DPT/OPV
3. CBC
4. Start oral penicillin prophylaxis, penicillin-V 125 mg bid
5. Review and reinforce the risk of serious infections, anemia and painful crises
6. Consider referral to a pediatric hematologist

6 months
1. Routine child health care
2. DPT
3. CBC
4. Review and reinforce the risk of serious infection, anemia and painful crises
5. Reinforce the need for penicillin prophylxis

9-24 months, see patient every 3 months
1. History and physical exam
2. CBC
3. Reinforce the need for prophylactic penicillin
4. Discuss possible complications such as infections, sepsis, meningitis, pneumonia, osteomyelitis, splenic sequestration, aplastic crisis, pain, dactylitis, vaso-occlusive crises, priapism
5. 15 months - MMR
6. 18 months - DTP/OPV, PRP-D (Haemophilus B Conjugate vaccine)
7. 24 months - Pneumovax (pneumococcal vaccine)

2-5 years, see patient every 3-6 months
1. History and physical exam
2. CBC
3. 3 years - Increase penicillin-V to 250 mg bid
4. 4 years - DPT/OPV booster
5. Parent education - review above mentioned complications
6. Yearly visits to pediatric hematologist suggested

pneumoniae and *Haemophilus influenzae*. Pneumococcal bacteremia has been reported to occur with an onset several hours after a dose of prophylactic penicillin was missed.[7] In addition bacteremia has occurred in children immunized with the pneumococcal vaccine. Since it contains only those serotypes most frequently causing infection, bacteremia could be due to one of the less common serotypes. It has also occurred with serotypes included in the vaccine but which provoke an inadequate antibody response.[8] Immunization with *Haemophilus influenzae* vaccine has been shown to be effective in hematologically normal children but no such studies have been done in children with sickle cell anemia.

Medical Management

1. Fever

Bacteremia and meningitis caused by *Streptococcus pneumoniae* and *Haemophilus influenzae* occur with an extremely high incidence in children with sickle cell anemia during the first five years of life. Children with Hemoglobin SC disease have been shown to have a comparable rate during the first two years.[3]

The frequency with which pneumococcal bacteremia occurs in children with sickle cell disease and the reported 14% mortality for such episodes[3] requires an approach different from what would be considered appropriate management for fever in hematologically normal children.

Parents must be instructed to watch carefully for fever in any age child but especially during the first five years of life. They should be taught to take temperatures and read the thermometer. If a fever is found, they should avoid the common practice of treating the fever rather than its cause. Since a minor temperature elevation might indicate a serious infection, the child should be evaluated by a physician whenever the temperature is above 101°F (38.3°C) or if the child is acting ill at any degree of fever. The evaluation should be accomplished as promptly as possible without waiting to see if the child is going to get better or worse.

It must be emphasized that sepsis can occur despite the fact that the child has been immunized and prophylactic penicillin is being given. Parents should also be informed that an extra dose of penicillin prophylaxis is not an appropriate substitute for bringing their febrile child for medical evaluation.

The evaluation of these children is difficult. Since pneumococcal bacteremia occurs with some frequency in hematologically normal children with temperatures above 103°F (39.5°C),[9] temperatures above this in children with sickle cell disease must be approached very cautiously.

Leukocyte counts cannot be relied upon to distinguish between viral and bacterial infections in hematologically normal children and seem to be even less reliable in sickle cell disease where baseline levels are elevated.[10] Similarly, the erythrocyte sedimentation rate[11] and C reactive protein levels[12] have both

been shown not to be helpful in identifying the presence or severity of infection. Finally, even the spinal fluid leukocyte count cannot be relied upon as an indicator of meningitis as documented in a report of six sickle cell anemia patients who had normal spinal fluid cell counts at the time of presentation with culture documented *Streptococcus pneumoniae* meningitis.[13]

Since there is no reliable laboratory test to distinguish viral from bacterial infections in the initial evaluation of febrile children, clinical signs must be relied upon. Their imprecision require that in most instances the child should be hospitalized, appropriate cultures obtained and parenteral antibiotics given. The antibiotics used should be effective against *Streptococcus pneumoniae* but if *Haemophilus influenzae* infections are frequently encountered, the antibiotic should also be chosen for effect against ampicillin resistant organisms.

Following admission, if the child defervesces and the blood culture shows no growth at 48 or 72 hours, treatment can be completed with oral antibiotics at home. When the child is found to have meningitis or bacteremia, the course of treatment is similar to that used in hematologically normal children.

If the fever is thought to be of viral origin or outpatient antibiotic treatment is believed to be a safe alternative a blood culture should be obtained and the parent instructed to be alert for changes in the child's condition and to return at once if it worsens. This approach is clearly risky and should only be considered if the child looks particularly well, the parents are known to be completely aware of the potential severity of the problem and can be expected to return at once if the child shows any signs of deterioration.

2. Pain

Although pain is the hallmark of sickle cell disease, many affected children never have pain sufficiently severe to require treatment. The cause for this differential severity is one of the many mysteries of this disease process and may be a key to developing treatment strategies.

When pain is encountered it may be related to fever, dehydration or hypoxia. It can also follow exposure to cold temperatures, weather changes and emotional stress. Mechanical or traumatic events that result in an interruption of blood flow to tissue can also result in erythrocyte sickling and subsequent severe pain.

For mild pain, the parent should be advised to encourage oral fluids at a rate of 1½ to twice maintenance (2,250 - 3,000 ml/m^2) to ensure hydration and to give acetaminophen for analgesia. The application of warm compresses or having the child relax in a warm bath may also be helpful. However, the greatest benefit will be derived from the parent's calm approach and reassurance that the pain will be controlled.

If the pain is too severe to respond to these measures, the child should be brought to the physician. If it is believed due to a vaso-occlusive event, subcutaneous morphine at a dose of 0.1 mg/kg may provide sufficient relief to allow the child to return home. There, acetaminophen with codeine or meperidine suspension may provide adequate relief for the duration of the painful episode. Only a small supply should be given since pain that persists for two to three days deserves reevaluation.

Pain that does not respond to these measures or is so severe that such treatment is inappropriate requires hospitalization. Intravenous hydration is a standard part of therapy for sickle cell pain although its benefit has never been proved. The projection of a calm, reassuring attitude by the physician and nurses will help reduce anxiety which can make pain much worse. Morphine sulfate should be given intravenously at a dose of 0.1 - 0.2 mg/kg every 2 hours.[14,15] Meperidine can be used at a dose of 1 - 2 mg/kg every 2 hours. Repeated doses of this drug should be given with caution since seizure activity can result from accumulation of one of its metabolites.[16] The doses listed are safe starting doses but may need to be increased to control particularly severe episodes.

The intravenous route is preferred since it provides a more predictable analgesic response. In addition it avoids the fibrosis that accompanies prolonged intramuscular administration of certain analgesics, especially meperidine.

Parenteral narcotic analgesics should be administered on a regular and *not* an as needed or prn basis since the pain can be expected to continue at the same degree of severity for several days. Additionally it has been established that narcotic analgesics given only on request result in poorer pain control and the need for larger doses. When the pain begins to diminish, the dose can be decreased gradually in increments of 10% or as tolerated until analgesia can be accomplished with oral medications. At this point it is very important to choose an appropriate dose when changing to oral medications keeping in mind that they will be absorbed more slowly and provide lower blood levels than if administered intravenously. Even more important is the fact that they will be given every four hours so that the oral medication must equal two of the doses being given parenterally. Table 3 lists the relative strengths for commonly used oral analgesics. Individuals may respond differently than would be expected from the doses listed.

Children under two years old are subject to a process involving the small bones of the hands and feet called sickle cell dactylitis or the hand-foot syndrome.[17] It results in considerable swelling and pain that persists for two to three weeks and is frequently so severe that parenteral narcotic analgesics are required. The pain gradually decreases but swelling and tenderness will persist for several weeks and may

Table 3.—Relative Potencies of Parenteral and Orally Administered Narcotic Analgesics Frequently Used for Treatment of Pain of Sickle Cell Disease.

Drug	Parenteral dose (mg)	Oral dose (mg)
Morphine	7.5	45
Meperidine	75.0	300
Codeine	130	200
Oxycodone	15	30

All doses correspond approximately to a parenteral dose of morphine of 7.5 mg. (Modified from J. Pediatr. 98:180-189, 1981.

require that mild narcotic analgesics such as acetaminophen with codeine elixir be given at home.

3. Splenic Sequestration

This severe, life-threatening complication may be encountered in any of the variants of sickle cell disease, usually occurring when the child is very young.[18] Splenomegaly is a common but not necessary pre-condition. It is frequently associated with febrile illnesses. The problem results from the sudden shunting of a volume of blood to the spleen sufficiently large to result in hypovolemic shock.

If a child is found to have splenomegaly on routine physical examination, the parents should be taught how to monitor its size by abdominal palpation. They should be informed of the implications of sudden onset of pallor and weakness and advised to determine if the spleen size has increased.

If their child becomes symptomatic and they believe they have palpated the spleen or believe an already enlarged spleen has increased further in size, they should proceed at once to the nearest medical facility. There they should provide this information to the medical personnel at once since considerable time might be lost if the child is assigned to the routine evaluation process common in busy emergency rooms.

For the child who presents with pallor, tachypnea, hypotension and increasing splenomegaly, laboratory evaluation will show the hemoglobin to be below baseline values with reticulocytosis and thrombocytopenia.

Treatment is directed toward correction of shock and includes crystalloid or colloid restoration of the circulatory volume. Blood transfusion is usually required, but one 10 ml/kg infusion of packed red cells is usually sufficient. Such treatment may cause the spleen to disgorge a large proportion of the trapped blood which can result in an unexpectedly high hematocrit and significantly increased viscosity which may then cause vaso-occlusive complications.

If splenic sequestration recurs, splenectomy should be considerd. For the very young child, chronic transfusion therapy has been recommended to prevent further sequestration episodes while preserving splenic function.[19]

4. Aplastic Crisis

The sudden cessation of erythropoiesis has been shown to result from a parvovirus infection[20] but may have additional etiologies. Due to extremely short red cell survival in sickle cell anemia, the hemoglobin will fall rapidly when red cell production is interrupted.

Parents can be instructed to observe for pallor and weakness. In this instance the process has a more gradual onset which makes it much more difficult to appreciate. They should palpate the abdomen for the presence of a spleen but bring the child for evaluation even if it is not found to be enlarged.

The diagnosis must be considered when the hemoglobin concentration and reticulocyte count are found to be much lower than baseline values. They can be observed at two to three day intervals until reticulocytosis occurs and the hemoglobin increases toward its baseline value. If the parents are not willing to comply with frequent return visits, if clinical signs of severe anemia develop such as dyspnea, tachycardia and tachypnea, or when the hemoglobin reaches 3-4 gm/dl, a packed red blood cell transfusion of 10 cc/kg should be given. Careful observation must then continue until reticulocytosis returns. The need for subsequent transfusion is very unusual.

5. Stroke

Cerebral vascular accidents occur in sickle cell anemia with an incidence much higher than found in normal subjects.[21] For children, the strokes are usually caused by thrombosis of the cerebral vessels. Large blood vessels are involved which results in extensive neurologic damage.[22] Adolescents and adults are more likely to have subarachnoid hemorrhages.[21]

When discussing this possibility with parents, they should be instructed to bring the child to medical care at once if seizures, extremity weakness, difficulty with speech, swallowing, vision or disordered sensorium is noted.

When a stroke occurs, the initial radiographic studies should be done without contrast since its use might increase blood viscosity sufficiently to cause further interruption of the already compromised circulation.[23] Certain types of contrast are said to cause few problems[24] but their use when vessels may be only minimally patent must be undertaken with caution.

Once the diagnosis is made, the hemoglobin S (or SC) concentration should be reduced to 20-30% as promptly as possible using exhange transfusion or erthrocytophoresis.[25,26] Care must be taken to ensure that the hematocrit remains low until the percentage of abnormal hemoglobin has been reduced to the above mentioned numbers since blood viscosity

increases exponentially with increasing hematocrit when the hemoglobin S concentration is high. (See 13. Transfusion Therapy)

To avoid the 66% recurrence rate,[21] transfusion therapy must be given at a frequency sufficient to maintain the abnormal hemoglobin(s) below 30%.[25] This usually requires transfusion at three to four week intervals. Unfortunately, the duration of this treatment has not yet been established. In one report, when transfusion was stopped in ten patients after one to two years, strokes recurred in seven.[27] This finding and the progressive neurologic damage caused by recurrent strokes has led many physicians to continue transfusion therapy indefinitely.

6. Priapism

The incidence of priapism is grossly underestimated since many families are too embarrassed to report its occurrence and will do so only when specifically asked.[28] The complication should be discussed with the child and his parents who can be informed that its usual manifestation is a brief, painful erection which frequently responds to various interventions at home. Possible approaches include relaxation in a warm bath or distraction with any type of physical activity. Masturbation should not be tried as it is unlikely to result in either ejaculation or detumescence.

Serjeant has described the occurrence of frequent brief episodes and has termed them "stuttering priapism." In a study conducted in adult subjects, this problem could be prevented by daily stilbestrol administration.[29] Certain side effects such as gynecomastia and failure of normal erection were encountered which the authors reported could be avoided by manipulation of the dose. No experience has been published regarding this form of therapy in children.

If an erection persists for three hours it is unlikely to resolve spontaneously and parents should be advised to bring the child to medical attention. Parenteral hydration and effective narcotic analgesia should be initiated and the abnormal hemoglobin reduced as quickly as possible to about 20% using exchange transfusion or erythrocytopheresis.

If detumescence does not occur within 24 hours surgical intervention is necessary. It has been reported that use of the Winter procedure has resulted in a decreased rate of impotence, which frequently follows a severe episode of priapism.[30]

7. Cholelithiasis

Thirty percent of children who have sickle cell disease can be shown to have gallstones by the time they are 18 years old. This increases to 70% by age 30.[31] Although such stones can result in right upper quadrant abdominal pain, it is important to distinguish between pain caused by vaso-occlusive crisis and cholecystitis. This high rate of surgical complications in sickle cell disease makes it unwise to perform cholecystectomy unless the stones are actually causing symptoms.

If the patient develops cholecystitis, medical management should be attempted while preparations are made for elective cholecystectomy. Transfusion should be considered to reduce the hemoglobin S (SC) concentration below 30% as discussed in Section 13.

8. Acute Chest Syndrome

Chest pain, cough, hemoptysis, low grade fever and pulmonary infiltrates occur frequently in sickle cell disease. Since it is usually impossible to determine whether pneumonia, pulmonary infarction or some combination of the two is causing such symptoms, the clinical presentation is referred to as the chest syndrome.[32]

In children the usual cause is infection. Many of the infections are due to *Streptococcus pneumoniae* but viruses are responsible for a considerable proportion. Other bacteria can be responsible including *Mycoplasma pneumoniae* which is reported to cause unusually severe pulmonary infections in these children.[33]

Pulmonary infarction is thought to be the most common cause of the chest syndrome in adolescents and adults. Since infections cannot easily be excluded and pulmonary infarction has no specific therapy, antibiotic therapy is frequently provided.

With any pulmonary process in sickle cell disease, oxygenation is a major concern. To compensate for chronic anemia, the oxygen dissociation curve is shifted to the left in affected patients. This allows more efficient oxygen delivery to the tissues. As a result, if hemoglobin is not fully oxygenated in the lungs, deoxygenation at the tissue level may be sufficient to cause sickling. Consequently patients who have the chest syndrome should have their oxygen saturation maintained at normal levels by increasing the concentration of inspired oxygen. Blood transfusion is indicated for those patients whose process is sufficiently severe to cause respiratory failure. The use of partial or complete exchange transfusion has been reported to be beneficial in such instances.[34] The simple transfusion of blood without exchange must be approached cautiously to avoid the problem of increased blood viscosity.

9. Leg Ulcers

Chronic leg ulcers are most often encountered between the age of 10-30 years.[35] Since they are thought to be related to vascular stasis and trauma, affected individuals should be encouraged to avoid standing for long periods and to protect their feet and ankles by wearing shoes and stockings. Adolescents should be instructed to seek medical attention for any

slowly healing lesion that occurs below the knee.

When an ulcer develops, it must be carefully debrided at frequent intervals to promote healing. If it persists, the skin of the affected extremity can be immobilized using a dressing or Unna Boot application. Rarely, ulcers are sufficiently resistant to treatment to warrant transfusion therapy. Unfortunately, they can be expected to recur after transfusions are discontinued.

Skin grafting is another possible approach and should probably be accompanied by transfusion therapy to facilitate successful engraftment. Since this does nothing to change the underlying cause (which is unknown), new ulcer formation will occur.

10. Osteomyelitis

Osteomyelitis is a frequently encountered complication in sickle cell disease. Salmonella or staphylococci are the organisms most commonly encountered although others such as *Streptococcus pneumoniae* are occasionally isolated. The differentiation between an acute bone infarct and early osteomyelitis is difficult to make. A variety of radioisotope techniques have been proposed but to date none have proved reliable. Application of magnetic resonance imaging may ultimately prove to be of benefit.

Salmonella osteomyelitis is so commonly thought of in association with sickle cell disease that other etiologies such as *Staphylococcus aureus* or other bacteria are not considered.[36] Care should be taken to determine the responsible organism when a radiographic diagnosis of osteomyelitis is made. If no organism can be isolated, antibiotics effective against both salmonella and staphylococci should be used.

11. Aseptic Necrosis of the Femoral or Humeral Head

Aseptic necrosis is encountered with a high frequency in adolescents and adults with sickle cell disease.[37] Parents and children should be instructed to report pain that persists in their shoulders or hips during periods between painful crisis episodes.

When the diagnosis is made, early symptomatic treatment should be provided to minimize pain. Necrosis of the humeral head seldom causes the degree of problem associated with the hip. Avoidance or minimization of weight bearing may allow some degree of healing to occur. Although there are several surgical approaches to the management of this problem, such as femoral head resection, implantation of a bone graft to attempt to slow its deterioration and hip fusion, the surgical implantation of a prosthetic device must be considered in the more advanced cases. Hip protheses are frequently implanted in adults[38] but surgeons are reluctant to provide this surgery for adolescents since the prostheses may need to be replaced as frequently as every 10-15 years. For technical reasons, only two to three replacements are possible creating the possibility that the patient may outlive the ability to replace the prosthesis.

12. Retinopathy

Adults with sickle cell anemia and even more often those with Hemoglobin SC disease can develop significant retinopathy which can result in loss of vision.[39] If discovered sufficiently early, certain ophthalmologic procedures can slow its progression. These problems may have their onset in childhood so annual ophthalmologic examinations should be started when the child is six years old.

13. Transfusion Therapy

As a result of observations that patients with any of the variants of sickle cell disease can develop cerebral thromboses while under general anesthesia, many medical centers caring for large numbers of such patients reduce the hemoglobin S (or SC) concentration below 30% prior to surgery.[40,41] This practice, while common, is by no means established scientifically. In fact a multicenter study has just begun to compare surgical and anesthesia related complications of children whose hemoglobin S (SC) has been reduced below 30% and those in whom the hemoglobin has simply been raised above 10 gm/dl.

If it is decided to lower the hemoglobin S (SC) below 30% prior to elective procedures, a series of simple transfusions at four to seven day intervals can be given. It is important not to allow the hematocrit to rise above 36% until the hemoglobin S (SC) concentration reaches 30% since the presence of poorly pliable, hemoglobin S containing cells results in dramatically increased viscosity above that level.[42]

If the hemoglobin S or SC must be rapidly reduced to allow emergency surgery or as part of the treatment for stroke or priapism, exchange transfusion must be done. This can be accomplished in children whose initial hematocrit is below 20% by administering a volume of packed red blood cells equal to 4% of body weight while removing an equivalent volume of the patient's blood. If the starting hematocrit is 20-30%, a volume of the patient's blood equal to 5% body weight should be removed and replaced with volumes of packed cells and crystalloid equal to 3% and 2% of body weight respectively. Finally, if the starting hematocrit is over 30%, the total volume of exchange should be 6% of body weight replacing equal volumes of packed cells and crystalloid (Table 4).

For children who require chronic transfusion therapy, iron overload is encountered and can result in life-threatening complications. Such children must have regular serum ferritin determinations and chelation begun when the level reaches 1,000 ng/ml. This can be accomplished using desferoxamine at a dose

Table 4.—Guidelines for Calculation of Volume of Blood to be Removed and Packed Red Cells and Fluid Replaced in Exchange Transfusion.

Baseline Hematocrit	Volume of Blood Removed	Volume Replaced Packed RBC	Volume Replaced Crystalloid
Under 20	4%	4%	
20 to 30	5%	3%	2%
Over 30	6%	3%	3%

Volumes are expressed as percent of body weight in kilograms. For example, a 24 kg child whose baseline hematocrit is 25 would have 24 x 0.0 = 1.2 kg (1,200 ml) of blood removed and replaced with 24 x 0.03 = 0.72 kg (720 ml) packed red cells and 24 x 0.02 = 0.48 (480 ml) normal saline or Ringers lactate.

of 25-40 mg/kg/day given by a 12 hour subcutaneous infusion using a portable, low volume infusion pump.

Summary • The institution of statewide hemoglobinopathy screening will result in the identification of a large number of infants with sickle cell anemia and related hemoglobin abnormalities. It will provide the opportunity to prevent certain complications and reduce the severity of others. In addition, through genetic counselling, families can be provided with information that will allow them to understand the risk for recurrence in future pregnancies.

References

1. Gaston, M.; Verter, J.; Woods, G., et al: Prophylaxis with Oral Penicillin in Children with Sickle Cell Anemia, N. Engl. J. Med. 314:1593-1599, 1986.
2. John, A.B.; Ramial, A.; Jackson, H., et al: Prevention of Pneumococcal Infection in Children with Homozygous Sickle Cell Disease, Br. Med. J. 288:1567-1570, 1984.
3. Zarkowsky, H.; Gallagher, D.; Gill, F., et al: Bacteremia in Sickle Hemoglobinopathies, J. Pediatr. 109:579-585, 1986.
4. Plotkin, S.A.; Daum, R.S.; Giebink, G.S., et al: PedComm: AAP Member Alert, 1988.
5. Overturf, G.D.; Selzer, J.W.; Chan, L., et al: Pneumococcal Polysaccharide Immunization of Children with Sickle Cell Disease. II. Serologic Responses and Pneumococcal Disease Following Immunization, Am. J. Pediatr. Hematol. Oncol. 4:25-35, 1982.
6. Weintrub, P.S.; Schiffman, G.; Addiego, J., et al: Long Term Follow-up and Booster Immunization with Polyvalent Pneumococcal Polysaccharide in Patients with Sickle Cell Anemia, J. Pediatr. 105:261-263, 1984.
7. Buchanan, G.R.; Siegel, J.D.; Smith, S.J., and DePasse, B.M.; Oral Penicillin Prophylaxis in Children with Impaired Splenic Function: Study of Compliance, Pediatrics 70:926-930, 1982.
8. Ahonakhai, V.I.; Landesman, S.H.; Firkig, S.M., et al: Failure of Pneumococcal Vaccine in Children with Sickle Cell Disease, N. Engl. J. Med. 301:26-27, 1979.
9. Wright, P.F.; Thompson, J.; McKee, K.T., et al: Patterns of Illness in Highly Febrile Young Child, Pediatrics 67:694-700, 1981.
10. Pegelow, C.; Powars, D., and Overturf, G.: Sickle Cell Disease, Am. J. Dis. Child. 133:448, 1979.
11. Lawrence, C. and Fabry, M.E.: Erythrocyte Sedimentation Rate During Steady State and Painful Crisis in Sickle Cell Anemia, Am. J. Med. 81:801-808, 1986.
12. Sprinz, P. and Pegelow, C.: Failure of C-reactive Protein to Predict Bacteremia in Children with Sickle Cell Disease, Clin. Res. 36:62A, 1988.
13. Rao, S.P.; Schmalzer, E.: Kaufman, M., and Brown, A.K.: Meningitis in Patients with Sickle Cell Anemia; Normocellular CSF at Initial Diagnosis, Am. J. Pediatr. Hematol. Oncol. 5:101-103, 1983.
14. Vichinsky, E.: Johnson, R., and Lubin, B.: Multidisciplinary Approach to Pain Management in Sickle Cell Disease, Am J. Ped. Hematol. Oncol. 4 328-333, 1982.
15. Cole, T.B.; Sprinkle, R.H.; Smith, S.J., and Buchanan, G.R.: Intravenous Narcotic Therapy for Children with Severe Sickle Cell Pain Crisis, AJDC 140:1255-1259, 1986.
16. Tang, R.; Shimomura, S., and Rotblatt, M.: Meperidine-Induced Seizures in Sickle Cell Patients, Hospital Formulary 15:764-772, 1980.
17. Stevens, M.C.G., Padwick, M., and Serjeant, G.R.: Observations on Natural History of Dactylitis in Homozygous Sickle Cell Disease, Clin. Pediatr. 20:311-317, 1981.
18. Topley, J.; Rogers, D.; Stevens, M., and Serjeant, G.: Acute Splenic Sequestration and Hypersplenism in First Five Years in Homozygous Sickle Cell Disease, Arch. Dis. Child. 56:765-769, 1981.
19. Rao, S. and Gooden, S.: Splenic Sequestration in Sickle Cell Disease: Role of Transfusion Therapy, Am. J. Pediatr. Hematol. Oncol. 7:298-301, 1985.
20. Kelleher, J.; Luban, N.; Cohen, B., and Mortimer, P.: Human Serum Parvovirus as Cause of Aplastic Crisis in Sickle Cell Disease, AJDC 138:401-403, 1984.
21. Powars, D.; Wilson, B.; Imbus, C., et al: Natural History of Stroke in Sickle Cell Disease, Am. J. Med 65:461-471, 1978.
22. Stockman,J.A.; Nigro, M.A.; Mishkin, M.M., and Oski, F.A.: Occlusion of Large Cerebral Vessels in Sickle Cell Anemia, N. Engl. J. Med. 287:846-850, 1972.
23. Imbus, C.; Powars, D.; Pegelow, C., and Segal, H.: CT Complications, Arch. Neurol....author: vol. pg. # 1978
24. Rao, V.M.; Rao, A.K.; Steiner, R.M., et al: Effect of Ionic and Nonionic Contrast Media on Sickling Phenomenon, Radiology 144:291-293, 1982.
25. Russell, M.; Goldberg, J.; Hodson, A., et al: Effect of Transfusion Therapy on Ateriographic Abnormalities and on Recurrence of Stroke in Sickle Cell Disease, Blood 63:162-169, 1984.
26. Sarniak, S. and Lusher, J.: Neurologic Complications of Sickle Cell Anemia, Am. J. Ped. Hematol. Oncol. 4:386-394, 1982.
27. Williams, J.; Goff, J.; Anderson, H., et al: Efficacy of Transfusion Therapy for One to Years in Patients with Sickle Cell Disease and Cerebrovascular Accidents, J. Pediatr. 96:205-208, 1980.
28. Emond, A.; Holman, R.; Hayes, R., and Serjeant, G.: Priapism and Impotence in Homozygous Sickle Cell Disease, Arch. Intern. Med. 140:1434-1437, 1980.
29. Serjeant, G.R.; De Ceulaer, K., and Maude, G.H.; Stilboestrol and Stuttering Priapism in Homozygous Sickle-Cell Disease, Lancet 2:1274-1276, 1985.
30. Noe, H.; Williams J., and Jerkins, G.: Surgical Management of Priapism in Children with Sickle Cell Anemia, J. Urol. 126:770-771, 1981.
31. Rennels, M.; Dunne, M. Grossman, N, and Schwartz, A.: Cholelithiasis in Patients with Major Sickle Hemoglobinopathies, AJDC 138:66-67, 1984.
32. Poncz, M.; Kane, E., and Gill, F.: Acute Chest Syndrome in Sickle Cell Disease: Etiology and Clinical Correlates, J. Pediatr. 107:861-866, 1985.
33. Shulman, S.T.; Bartlett, J.; Clyde, W.A., and Ayoub, E.M.: Unusual Severity of Mycoplasmal Pneumonia in Children with Sickle Cell Disease, N. Engl. J. Med. 287:164-167, 1972.
34. Davies, S.C.; Luce, P.J.; Win, A.A.; Riordan, J.F., and Brozovic, M.: Acute Chest Syndrome in Sickle-Cell Disease, Lancet 1:36-38, 1984.
35. Wilfort, F.G. and Krizet, T.J.: Skin Ulceration in Sickle Cell Anemia, Plast. Reconstr. Surg. 43:71-77, 1969.
36. Givner, L.; Luddy, R., and Schwartz, A.: Etiology of Osteomyelitis in Patients with Sickle Hemoglobinopathies, J. Pediatr. 99:411-413, 1981.
37. Hawker, J.; Neilson, H.; Hayes, R., and Serjeant, G.: Hematologic Factors Associated with Avascular Necrosis of Femoral Head in Homozygous Sickle Cell Disease, Br. J. Hematol. 50:29-34, 1982.
38. Gunderson, C.; D'Ambrosia, R., and Shoji, H.: Total Hip Replacement in Patients with Sickle Cell Disease, J. Bone Joint Surg. 59A:760-762, 1977.
39. Goldberg, M.F.: Natural History of Untreated Proliferative Sickle Retinopathy, Arch. Ophthalmol. 85:128-137, 1971.
40. Fullerton, M.W.; Philippart, A.I.; Sarnaik, S., and Lusher, J.M.: Preoperative Exchange Transfusion in Sickle Cell Anemia, J. Pediatr. Surg. 16:297-300, 1981.
41. Charache, S.; Lubin, B.; Reid, C.D. (eds): Management and Therapy of Sickle Cell Disease, U.S. Dept. Public Health and Human Services, NIH Publication No. 84-2117, 1984, pp. 8-10.
42. Schmalzer, E.; Chien, S., and Brown, A.K.: Transfusion Therapy in Sickle Cell Disease, Am. J. Pediatr. Hematol. Oncol. 4:395-406, 1982.

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Hernia Repair in the Aged and Infirmed

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ABSTRACT: This report reviews a two-year personal series of 175 consecutive patients, 66 years or older, for whom unilateral or bilateral inguinal or femoral hernias were repaired. The majority of these patients had significant coexistent medical problems. No patient was excluded for reason of disease.

Considering the severity of their medical ailments, 58% of patients were designated Class III according to the American Society of Anesthesiologists Classification of Physical Status. Twenty-two patients previously had coronary artery bypass or PCTA procedures. Preoperatively the majority of patients were on single or combined treatment with nitrates, beta blockers, calcium channel blockers, antihypertensives, and antiarrhythmics.

Patients were designated as being of elective (reducible or long-standing incarcerated hernia without pain or tenderness), urgent (recent incarceration without or with minimal pain but without tenderness), or emergency (recent or long-standing incarceration with acute pain or tenderness) status. Most surgical procedures were done using local or epidural anesthesia. Strangulated (reversible or irreversible tissue changes due to constriction of venous and/or arterial blood flow) tissues were found in 19 patients, the majority of whom presented with first-time or multiple-time recurrent hernias.

Prompt diagnosis and treatment, preoperative control of systemic disease, proper choice of anesthesia, and avoidance of surgical complications were the underpinning of the surgical results obtained in this series.

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While emergency surgery for abdominal hernia repair carries a frighteningly high risk in aged and infirmed patients, the result of this series supports the postulate that properly-timed elective surgery can be done without excessive morbidity or mortality. Symptoms which most commonly precipitate hernia repair surgery in elderly or infirmed patients are pain or acute increase in the size of their incarcerated hernia.

In their five year study of 62 patients older than 70 years, Tingwald and Cooperman reported that four patients died of myocardial infarction, a 6% mortality.[1] In Nehme's multihospital study of 1,496 geriatric hernia repairs done over a ten year period, the mortality was 7.5%.[2] Williams and Hale report a 3.7% mortality over ten years in 270 hernia repair patients who were 60 years or older.[3] Four of the 222 elective patients and six of the 48 emergency patients died (Table 1). In those reports, the maladies most often noted include cardiovascular disease, genitourinary disease, cancer, pulmonary disease, diverticulosis coli, and diabetes mellitus. Most common in elderly males was benign prostatic hypertrophy, essential hypertension, cancer of the prostate, chronic obstructive pulmonary disease, and a prior cerebrovascular accident. In females, prior myocardial infarction, essential hypertension, congestive heart failure, and diverticulosis coli were most frequently encountered.

Materials and methods ● In the two years from January 1986 through December 1987, I repaired inguinal or femoral, unilateral or bilateral, hernias in 727 patients. Included in this group were 175 consecutive patients 66 to 94 years of age most of whom had various medical maladies. This subgroup was comprised of 154 males and 21 females; 165 repairs were done for primary hernias, and 17 for recurrent hernias. In seven patients, simultaneous bilateral repairs were done (Table 2). Twenty-seven (15%)

Table 1

Author	Number Patients	Youngest Age	Mortality
Tingwald & Cooperman	62 - 5 yr.	70	6%
Nehme	1496 - 10 yr.	65	7.5%
Williams & Hale	270 - 10 yr.	60	3.7%
Gilbert	175 - 2 yr.	66	0%

Table 2.—Number of Patients and Procedures.

175 Patients 66 to 94 years
Males –154 Females –21
182 Repairs
165 Primary hernias
17 Recurrent hernias
7 (Bilateral)

patients gave the history of one or more myocardial infarctions; 28 (15%) had angina; ten (50%) had cardiac arrhythmias; 31 (17%) were being treated for congestive heart failure, and 24 (12%) previously had anticoagulant therapy. Only in terms of numerical correlation to malignant diseases, in the group of 17 females, eight previously had carcinoma of the breast. In males, prostatic and colon cancer were most frequent, historically present in 17 patients (Table 3).

The majority of these patients were on singular or combined treatment with nitrates, beta blockers, calcium channel blockers, antihypertensives, and antiarrhythmics. Twenty-two patients previously had undergone PTCA or coronary artery bypass procedures. Using the American Society of Anesthesiologists Classification of Physical Status, four patients (2%) were Class 1; 35 (20%) Class 2; 100 (58%) Class 3; 36 (20%) Class 4 (Table 4).

Medical management was done preoperatively in most cases by the primary physician. In cases planned for local or epidural anesthetic, it was believed unnecessary to do any extensive function studies such as stress tests or pulmonary studies. The information necessary to decide the patients tolerance for the procedure was best judged from the history of his ability to walk a noninclined city block or a portion thereof; or his ability to climb stairs and do his routine functions. Any baseline testing for the occasional patient needing general anesthesia served primarily as a point of reference should a postanesthetic complication occur. All patients underwent fine-tuning of their cardiovascular medications and, if necessary, replacement therapy to establish electrolyte balance. In 20 patients, aspirin or anticoagulants were withdrawn. One patient on aspirin therapy and another patient on anticoagulant therapy required emergency surgery.

When first seen 15 patients were considered of emergency status and operated on that same day.

Table 3.—Coexisting Conditions.

	Number Patients	Per cent
Myocardial infarction	27	15
Angina pectoris	28	15
Arrhythmia	10	5
Congestive heart failure	31	17
Anticoagulant or ASA	24	12
Cancer of breast	8	38
Cancer of prostate or colon	17	11

Table 4.—ASA Classification of Physical Status.

1. A normal, healthy patient for an elective operation
2. A patient with mild systemic disease
3. A patient with severe systemic disease that limits activity but is not incapacitating
4. A patient with an incapacitating systemic disease that is a constant threat to life
5. A moribund patient who is not expected to survive for 24 hours with or without the operation

Twenty-nine additional patients were considered of urgent status by way of recent incarceration accompanied by no more than minimal pain and without tenderness. Most patients in this group were repaired within 24 hours. However, surgery was delayed in some patients as long as 72 hours while they were cautiously monitored and prepared to be better surgical risks. The remaining 131 patients were considered of elective status and were scheduled conveniently. The technique of anesthesia was local in 124 patients, epidural in 34 patients, and general inhalation in 17 patients (Table 5).

Table 5.—Presentation.

	Number Patients	Edema	Strangulation
Emergency	15	14	10
Urgent	29	9	2
Elective	131	7	0
Anesthesia			
Local	124		
Epidural	34		
General	17		

Results ● Of the 15 patients in the emergency group, ten were found to have strangulated tissue. Omentum and bowel were involved alone or in combination. In no case had the impairment of vascular supply progressed enough to require a bowel resection. In six patients, partial omental resection was done. Five patients suspected preoperatively of having

strangulated tissues did not have macroscopic evidence to confirm it, but did have edema. Of the 29 patients considered urgent, some degree of visible edema or stangulation was evident in 11 cases. Two had strangulated tissues. In no case had bowel necrosis occurred. Of the 131 elective patients, seven showed edema of tissues which was totally unsuspected before surgery.

Of the 175 patients, 38 had partial or completely incarcerated hernias. Twenty-six of these had sigmoid colon or bladder in a sliding component. Of the incarcerated hernias, nine were recurrent, 29 were primary. Of the ten strangulated hernias, five were primary and five recurrent. Of the five primary strangulated hernias, two were femoral, two indirect, and one direct. Of the recurrent strangulated hernias, one was femoral, three indirect, and one direct (Table 6).

Table 6.—Incarceration/Strangulation.

			Number Patients
Incarcerated			38
Primary		29	
Recurrent		9	
Strangulated			10
Primary			5
Femoral	2		
Indirect	3		
Direct	1		
Recurrent			5
Femoral	1		
Indirect	2		
Direct	1		

There were no operative deaths. One 83-year-old male died of a cerebrovascular accident five weeks after discharge. One 81-year-old female died of a myocardial infarction six weeks after discharge. No wound infections occurred. Five patients had postoperative wound hematomas, each of whom had been on aspirin or an anticoagulant prior to surgery. In eight of the patients, either known preoperatively or diagnosed postoperatively to have congestive heart failure, a wound seroma formed five to seven days after surgery. Four of the 17 patients having general anesthesia and one of the 124 patients having local anesthesia required urinary catheterization after surgery. Combined tissue and prosthetic graft repairs were done in most cases. Though no recurrences have been identified in this closely followed group, insufficient time has elapsed to specify a precise rate of recurrence (Table 7).

Table 7.—Results

Wound hematoma	5
Wound seroma	8
Wound infection	0
Urinary catheterization	5
Deaths	0
Recurrences	0

Comments ● Surgery for abdominal hernia in the aged or infirmed need not carry a high rate of mortality or morbidity. The presence of a hernia is usually known by the patient and his primary care physician. Reluctance on the part of the patient to deal with this common malady is based mostly on fear. This includes fear of the hospital; disability from an anesthestic; of finding cancer; or of death. Also expressed by some patients are concerns of minimal life expectancy and of creating additional financial expenses so late in life.

Primary care physicians disinclined to have early surgery for elderly patients with hernia disability have expressed these reasons and assumptions: (1) the patient has numerous complaints of which the hernia is just one of many; (2) the patient is usually taking multiple medications, and (3) the patient will require a general anesthetic which will be tolerated poorly. In so thinking, many physicians fail to consider the unnecessary invalidism forced on their patients who have coexistent bladder, bowel or pulmonary disabilities.

Minimizing morbidity and mortality associated with hernia repair surgery in older people should be directed toward prompt diagnosis and treatment; preoperative control of systemic diseases; proper choice of anesthesia; competent and expeditious repair, and avoiding complication of surgery.

Conclusion ● Neither increased age nor coexistent medical maladies necessarily forecast greater morbidity or mortality when the patient is suitably prepared for elective hernia repair. Preoperative medical evaluation and early postoperative ambulation with resumption of usual activities assists in the achievement of an ideal outcome. When done with local anesthesia elective surgery performed early promises the fewest complications.

References

1. Tingwald, G.R., and Cooperman, M: Inguinal and Femoral Hernia Repair in Geriatric Patients, SG&O 154: 704-706, 1982.
2. Nehme, A.E.: Groin Hernia in Elderly Patients — Management and Prognosis, Amer. J. Surg., 146: 257-260, 1983.
3. Williams, J., and Hale, H: Advisability of Inguinal Herniorrhaphy in the Elderly, SG&O Jan 1966, 100-104

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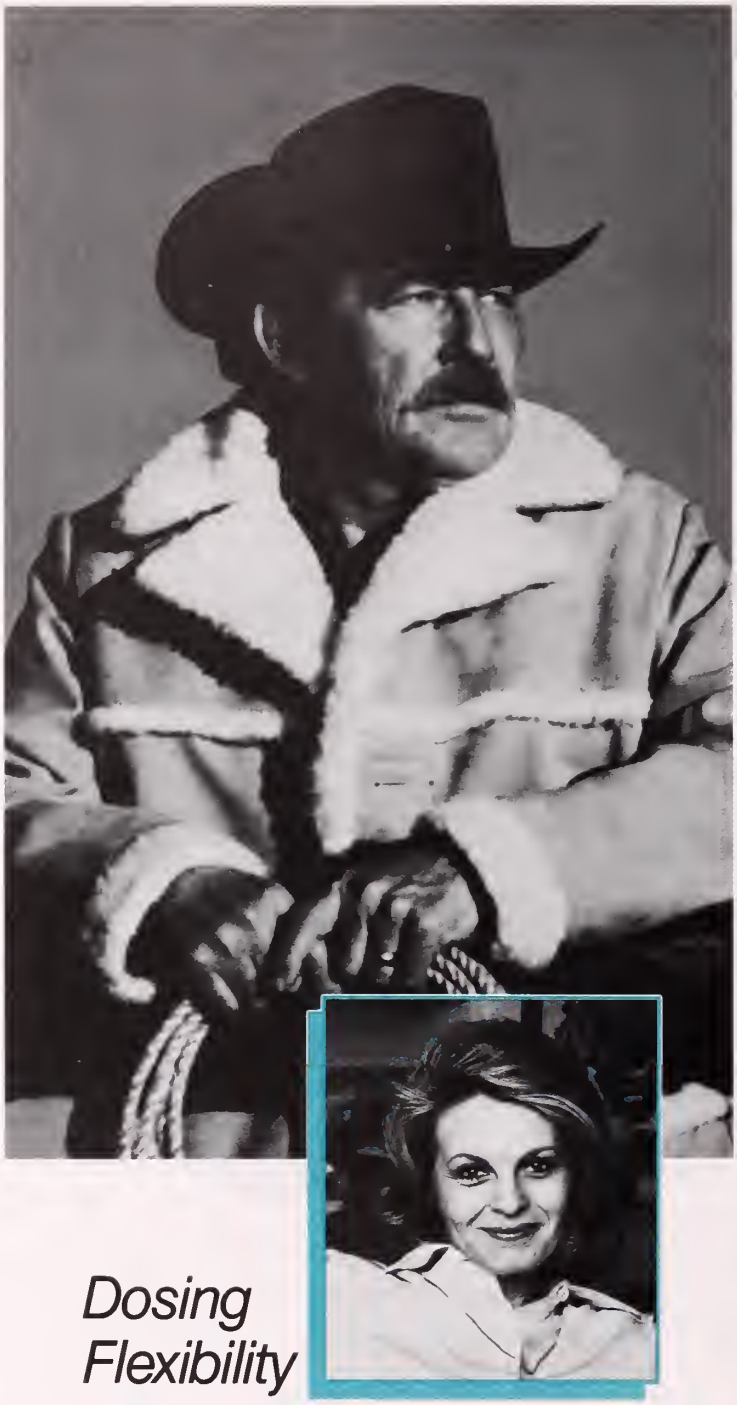

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The Harvard Resource-Based Relative Value Study: Implications for Physician Reimbursement

Health care expenditures for physician services increased at a 15% compounded rate between 1975 and 1987[1] while the per capita gross national product went up 7.9%. These figures have convinced government managers that physician fees must be curtailed. Government assumptions state that (a) many services such as pacemaker implantations, coronary angiograms, upper GI endoscopies, and carotid endarterectomies are performed excessively and unnecessarily;[2,3] (b) the prices government pays for physician services can be used to achieve both cost containment and access to high quality of care; (c) reimbursement schedules are economic incentives that influence doctors' clinical decision making, practice locales, and specialty selection; and (d) the fee-for-service system, based upon the concept of "customary, prevailing and reasonable" (CPR system), is antiquated and inflationary. Any physician adequately versed in medical economics could strenuously counterattack the legitimacy of each of these assumptions. However, their reasonableness has been well accepted by the Congress which promulgated creation of the Physician Payment Review Commission in 1986. The Commission was directed to develop alternative methods of reimbursing physicians. The initial effort of this Commission was development of a relative value fee schedule based on the resource costs to the doctor of the services he or she provided.

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Relative value schedules • Relative value fee schedules are well known to Florida medical practitioners. Previous relative value schedules have been designed by establishing the median physician charge for a given service procedural code and then ranking the worth of different procedures by their median numbers. Such a schedule was obviously driven by historical charges; it was lopsided in favor of interventional codes. It did not adjust for physician time, experience, skill, future earnings lost due to specialty training, overhead costs to the physician, intensity of the service rendered, its risks to the patient and the doctor, the stress factors involved in performing the service or the economic value of the procedure to the patient or to society.

Professor William C. Hsiao, at the Harvard School of Public Health, initiated a series of studies in the 1970s to establish relative value schedules for doctor services based on the costs to the physician of providing these services.[4,5] He and his coinvestigators measured and incorporated five physician resources (costs) into their value estimates: (a) the time involved to perform a procedure or an encounter such as an office visit; (b) the time that was spent before and after the service was performed such as the time in talking to families, conducting paperwork, etc.; (c) the complexity or intensity of the service or procedure; (d) overhead costs, including malpractice costs; and (e) the amortized values of the wages lost by the additional time spent in specialty residency training.

The original studies found that physicians underestimated the total time involved in performing procedures or delivering management and diagnostic services and that they overestimated the complexity of the services performed. The studies also identified the great discrepancy in reimbursement between invasive and cognitive services: for a given resource input one physician might be reimbursed two to three times more than another specialist performing some other task that required equal resource input. Economists have postulated that these inequities influence the choice of specialties by medical students and skew the choice of alternative treatments towards

the performance of high cost services. The truth of this postulate has never been investigated.

Harvard study ● The most recent study by Dr. Hsiao and his colleagues has just been completed and has been discussed in the lay press and in several recent journal articles.[6-8] It is not the purpose of this report to discuss the methodology, statistics or procedural limitations of the study itself. Its conclusions indicate that the services of some family physicians and non-procedural internists are reimbursed at levels that should be increased 50% to 60% in some instances while certain operative procedures, such as coronary artery bypass surgery and lens implantation, should be reduced by a similar amount if the physician Medicare reimbursement is to be kept cost-neutral. Selected resource-based, relative value figures are listed in Table. I.

Table 1.—Practice Costs as a Percentage of Gross Revenue; Selected Specialties.

Specialty	Practice Cost/ Gross 1983	Revenue Ratio 1986
Gen. Prac./Fam. Med.	54.3	59.9
Int. Med.	48.3	50.3
Gen. Surgery	43.8	47.8
Pediatrics	47.5	53.3
Ob/Gyn	47.9	52.3
All Physicians	45.1	49.8

The study has acknowledged and documented that the CPT-4 procedural code book, which is employed by most third party payors and by Medicare, is inadequate as a document for facilitating doctor reimbursement for medical services. The codes for cognitive skills are particularly restrictive, ambiguous and unfair. For instance, it was found that a rheumatologist expends three times more resources in the performance of an extended new patient evalution (Code #90020) than does a dermatologist. Yet the reimbursement for the procedure is the same for both physicians. There are no coding procedures for adjusting for these differences in physician costs. Similarly, there are too few methods of adjusting for the management of the chronically ill patient who has a multitude of complex problems.

Conversely, the CPT manual permits a variety of codes for procedural services and the number of such codes are excessive. The large number of different procedural codes allow some specialists to enhance reimbursement by fractionating a given service into multiple compensable components. The Harvard study calls for fewer procedural codes and an expansion of the number of cognitive service codes.

The study's estimate of work input was fair. It divided work input into four components: time; mental effort and judgment involved; technical skill needed and physical effort expended; and psychological stress involved. For each procedure total work was estimated by the above criteria. The work component of the relative value scale was then expressed as the amount of work expended per unit time. It was found that work per unit time varied minimally for the cognitive specialists but varied over a tenfold range for the surgical and procedural specialists.

The study also identified, measured, and factored into the RBRVS the amount of work performed by the doctor before and after performance of the procedure or cognitive encounter for which patients are billed. One third of the cognitive specialist's resource input and over half the resources used by the procedural specialist are expended on pre- and postprocedural activities such as patient chart reviews, manipulating the medical records, speaking with family members, talking to other physicians about the patient, providing routine pre- and postoperative care, responding to nursing phone calls, abnormal laboratory results, etc.

The study has also incorporated differences in the costs of overhead for the various specialists (Table 2). For instance the overhead costs of the orthopedic surgeon and the rheumatologist are over twice that of the pathologist.

Its flaws ● The Harvard study has, for the first time, allowed health care administrators and doctors with a means of distinguishing and accounting for differences in the work inputs of the various tasks that we doctors perform. However, the study has several flaws and most of these have been acknowledged and identified by the authors.

The first flaw is that the study does not adjust for the different skills of different physicians. One physician may perform in a more cost effective way and utilize fewer Medicare resources in performing a given service or for caring for a particular disease. A more skilled doctor may be asked to see more patients with more complex problems. Under the Harvard RBRVS the skilled physician is not rewarded for his/her superior capabilities. Similarly, there is no adjustment for the experience of the physician performing the service. It is assumed that a more experienced physician will perform a procedure with fewer complications and lower cost than a less experienced physician. None of these differences, which could account for significant quality disparities, are accounted for in the RBRVS.

Secondly, the RBRVS does not measure the benefit of the service to the patient, to society, or to the payor. The study measures service inputs by the doctor but does not allow for patient outcomes. Obviously, this is not possible in 1988 because outcome data for much of what we do have never been gathered; it will be decades before we can correlate resource input with patient benefit.

Third, the study does not account for patient demands for a given service. This fact may alter the

Table 2.—Overhead Costs for Selected Specialists: 1983 and 1986.*

Code	Specialty	Service Description	RBRV
00562	Anesthesia	anesth, heart vessel repair, with pump oxy	928
00910	Anesthesia	anesth, transurethral procedures	118
11110	Dermatology	skin biopsy, single lesion	89
20610	Rheumatol.	inject/drain joint/bursa	109
27130	Orthopedics	total hip joint replacement	2903
31365	Otolaryng.	laryngectomy, radical neck dissection	2894
31621	Thor. Surg.	bronchoscopy, diagnostic	409
33512	Thor. Surg.	coronary artery bypass; 3 cor. art. graft	2871
44950	Gen. Surg.	appendectomy	621
49505	Urology	inguinal hernia repair	491
52336	Urology	cystoscopy, stone removal	1414
58150	Obstetrics	total hysterectomy	1007
63017	Orthopedics	removal of spinal lamina, lumbar	2723
66984	Ophthalmol.	remove cataract, insert lens	1592
71111-26	Radiology	x-ray exam of chest, 2 views	22
90020	Dermatology	office visit, new, comprehensive	113
90020	Rheumatology	office visit, new, comprehensive	355
90060	Fam. Pract.	office visit, established, intermediate	85
90060	Gen. Surg.	office visit, established, intermediate	64
90060	Obstetrics	office visit, established, intermediate	101
90220	Gen. Surg.	hospital care, new, comprehensive	183
90220	Intern. Med.	hospital care, new, comprehensive	226
81000	Intern. Med.	urinalysis with microscopy	16

*Adapted from Hsiao, W., et al, reference 9, table 82, volume 1, page 638.

effect of reducing the remuneration of highly valued services such as lens implantation after cataract removal or coronary bypass surgery. These procedures would probably continue to be demanded by patients because patients assign a high value to maintaining their eyesight or to delaying the risk of death due to a myocardial infarction. Therefore, physicians who perform these services might be able to resign from the Medicare system without significantly curtailing their income.

Fourth, the study still depends upon the currently available CPT-4 codes which do not account for the vast discrepancies in the interpretation of these codes by physicians practicing different specialties.

Fifth, the adoption of the RBRVS would not provide any mechanism for adjusting for future changes in the overhead costs of different specialists. The ratio of costs to revenues has significantly changed during the past five years. It will most certainly change even more in the future.

Sixth, the Harvard study has recommended no conversion factors by which the relative values may be translated into the dollar values for physician reimbursement. Conversion factors may become politically powerful weapons by which payors and government can influence policy. For instance, higher conversion factors might be allotted to doctors practicing within regions, such as the inner city, which are unattractive to and underserved by most doctors. Preventive services may be more highly compensated because of the assignment of a higher conversion factor to them.

Seventh, there is no information that would indicate that the adoption of the Harvard RBRVS will reduce costs for physician services to the Medicare system. If remuneration for currently highly priced, but relatively lower valued RBRVS procedures, such as ocular lens implants, is reduced, will ophthalmologists stop treating such patients under the Medicare system? Will they stop accepting assignment for these services, as they currently do? Attempts to limit physician fees by payors other than Medicare, such as HMOs and PPOs, have not reduced their cost of providing medical care. Why should drastic cutbacks in physician remunerations succeed for Medicare? Furthermore, much of the increased cost of physician reimbursement has arisen from increased utilization of services. Some of this increase has resulted from the availability of high-technology services such as magnetic resonance imaging scans; some of it results from the practice of defensive medicine that is encouraged and demanded by the malpractice blight. Some of the increased utilization is due to increased patient demands for service. Since Medicare patients have not had to pay for any of their laboratory tests, they have become most anxious to have more lab services performed. A recent example is the exaggerated demand for the measurement of

serum cholesterol and high density lipoproteins.

Long-term effects ● The long-term effects on Medicare expenditures by the sudden imposition of the Harvard RBRVS on the physician reimbursement system are unpredictable. This uncertainty has fostered suggestions that the RBRVS be introduced slowly over several years and that a system of continual surveillance of its effects on Medicare costs be maintained.

A rapid and severe cutback in fees paid to some physicians threatens indigent patient care. Doctors have traditionally funded their costs of providing care to the poor from revenues received for the care of paying patients. If Medicare suddenly reduces some physician reimbursement, the victimized physicians will most likely severely reduce nonemergent care to the poor. Many doctors expect an incessant pressure for further fee curtailment in the face of constantly rising overhead costs. Many of these doctors will try to maximize current income by severely restricting their unreimbursed services to the indigent.

One final caveat is in order. The promise of higher fees for the cognitive specialists at the expense of the procedural specialists contains the seed of a potential schism between these two groups of doctors. This potential division in the ranks of medicine is reprehensible and must not be permitted. Such a division between the hospital-based specialists and the office-based general practitioners in Great Britain in 1946 sapped the political power of the doctors and permitted introduction of the National Health Service by the Bevan government. Let us learn from this British tactical mistake. We can discuss the merits and limitations of the RBRVS among ourselves; we must not let the discussion deteriorate into an emotional battle in which we compromise our loyalty to medicine and to the fine tradition of private practice that we have enjoyed in this country. If we permit serious confrontation among different groups of doctors, we will all become unwilling conscripts of government.

References

1. Chassin, M.R., et al: Does Inappropriate Use Explain Geographic Variations in Use of Health Care Services? Study of Three Procedures, JAMA 258:2533-2537, 1987.
2. Greenspan, A.M., et al: Incidence of Unwarranted Implantation of Permanent Cardiac Pacemakers in Large Medical Popultion, N. Engl. J. Med. 318:158-163, 1988.
3. Hsiao, W.C. and Stason, W.: Toward Developing a Relative Value Scale for Medical and Surgical Services, Health Care Financ. Rev. 1:23-28, 1979.
4. Hsiao, W.C., et al: Resource-Based Relative Value Scale: Toward Development of Alternative Physician Payment Scale, JAMA 258:799-802, 1987.
5. Roper, W.L.: Statement before the Subcommittee on Health of the Committee of Ways and Means, U.S. House of Representatives, U.S. Dept. of Health and Human Services, Health Care Financing Administration, 1988.
6. Hsiao, W.C., et al: Estimating Physicians' Work for Resource-Based Relative-Value Scale, N. Engl. J. Med. 319:835-841, 1988.
7. Hsiao W.C., et al: Results and Policy Implications of Resource-Based Relative-Value Study, N Engl. J. Med. 319:881-888, 1988.
8. Roper, W.L.: Perspectives on Physician-Payment Reform. Resource-Based Relative-Value Scale in Context, N. Engl. J. Med. 319:865-867, 1988.
9. Hsiao W.C., et al: National Study of Resource-Based Relative Value Scales for Physician Services: Final Report to Health Care Financing Administration, No. 18-C-98795/1-03, Boston, Harvard School of Public Health, September 1988.

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The Harvard Resource-Based Relative Value Study: A Surgeon's Critique

The recent study on relative values of physicians services, published by Hsiao and his colleagues, threatens to open a rift in the medical profession by transferring payments from procedures specialists to cognitive specialists. Such a radical reimbursement alteration is proposed to correct many of the purported inequities in the American medical care system: inflationary pressures on the costs of medical care will automatically abate, physicians will joyfully move into rural and other medically underserviced areas to provide care, and doctors will spend more time with their patients. Unfortunately, the ability of the Harvard Resource-Based Relative Value Study (RBRVS) to resolve these issues is built upon a scaffolding of false assumptions.

Victims of unfairness ● The first misconception of the study is that doctors and patients are "victimized by the unfairness" of the current reimbursement system. Most doctors would be hard pressed to identify patients or physicians who are "victimized" by the current system so extremely that they are demanding change. The authors of the study state that "customary, prevailing and reasonable (CPR) fee schedule are costly, unpredictable and inequitable." What are the data that prove this contention? If the CPR system is abandoned and replaced by the RBRVS will this not merely transfer presumed inequities from one group of practitioners to another? The RBRVS is merely a system of creating a distortion in the way that surgeons are reimbursed.

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Work compared on same scale ● The RBRVS assumes that the work of surgical and cognitive specialists can be compared on the same scale. Previous relative value scales prepared by the California and Florida Medical Associations found that such parallel comparisons were not possible between the two types of physician care. The Hsiao study made the comparison by creating an index of "total work" for various physician services and then ranking the services by the total amount of work and doctor resources that were consumed to provide these services. The definition of "total work" contained several components. One was time involved to produce a service. Another was "intensity" of the work input. One criterion used to estimate intensity was the psychological stress. Psychological stress is an intangible item which is difficult to quantify in dollar values. The study authors are comparing apples to oranges and coming up with a pomelo.

Save Medicare money ● The study assumes that adoption of the RBRVS will save the Medicare system money by reducing the economic incentives or inappropriate use of high-cost technology. How much of high technology use is really inappropriate? The vast majority of doctors are good, honest and competent. Doctors use high-cost technology because it improves patient care, not to enrich themselves or their colleagues. The study also assumes that better reimbursement of cognitive services, achieved through office visits rather than use of invasive procedures, will reduce the frequency of unnecessary surgery and diagnostic procedures. This conclusion is unsound and based upon the unfounded postulate that these services are grossly overutilized.

The RBRVS authors state that "Evaluation and management services performed in hospitals are compensated at a higher rate than the same services performed in office settings. Perhaps this phenomenon could be attributed to historically more complete insurance coverage of hospital services." This reflects a lack of understanding of the reasons for higher charges for seeing a patient in the hospital rather

than in the office. It has nothing to do with insurance coverage. Treating patients in the hospital is more time consuming; it frequently involves personal visits to the laboratory or radiology or pathology departments and discussion of the patient's problems with colleagues and families.

Encouragement to specialize ● The study also assumes that the current distortions in the fee schedule structure encourages doctors to specialize and to practice in urban and suburban areas, rather than encouraging primary care, rural care and out-of-hospital services. These statements are erroneous. The reason for specialization is not based upon economic incentive. The vast amount of knowledge that must be mastered for the practice of medicine makes it impossible for one practitioner to know enough to adequately provide the health care needs of all his or her patients. The desire to specialize reflects a deep personal concern by each one of us to be as good as we possibly can in one particular field. Furthermore, the decision to practice in urban and suburban areas is dictated, not by fee schedules, but by the desire to deliver the best medical care possible to our patients. Doctors require equipment, facilities and sophisticated services to deliver top quality care. These services and facilities are not available in many rural communities. Our knowledge of what represents excellence compels us to an ethical standard to give the best possible care. The legal climate in which we practice insists upon the same ultimate, high-tech standards. Practicing in a technologically deprived service area answers neither these ethical needs nor the legal demands of our times. The RBRVS will not change these realities.

Spend more time with patients ● The authors of the study imply that adoption of the RBRVS will permit doctors to spend more time with patients. The time that each physician spends with each patient is predicated upon the needs and demands of the particular patient, not the fee schedule.

The RBRVS is not the answer to health care cost containment in the United States. The RBRVS will simply factionalize the medical profession into armed camps warring with one another.

No decrease in costs ● The public and Congress want to see health care costs decrease. However, health care costs will not decrease. As long as members of the American society have the highest standards of living in the world they will demand, with increasing appetites, the best quality medical care they can afford. This fact of economic history is inexorable. Government has tried to reduce health care costs by increasing the numbers of physicians. Such an increase will theoretically increase competition among doctors and drive down health care costs. But government did not recognize that increased access to more doctors would increase the public's utilization of health care services; thus costs increase with increased numbers of physicians. Congress has inflicted medicine with the Health Care Financing Administration (HCFA) which is a structure that was designed to down-regulate health care costs by bureaucratic dictate; yet health care costs have risen at twice the rate of inflation in the United States since HCFA has been interfering with the practice of medicine. Price controls have never worked for any other economy in history. Why should they be expected to work in the American economy when applied to medicine?

Cost containment efforts ● Congress should focus its health care cost containment efforts at reducing doctors' costs of practicing medicine. Ever-increasing malpractice premiums, regulatory dictates, and paperwork requirements are among the chief causes of increased costs for physician services. Another cause is the increasing demands for services by patients — particularly the elderly. These demands are due to their increased awareness of the technological advances in medicine coupled with their near total relief from the responsibility to pay for such services. Why should the wealthy elderly not be responsible for more of their own care, rather than depending on government?

The present Medicare system is a giant giveaway to the wealthiest group of people in American society — the retirees. Providing 80% of the cost of care to all members of the elderly group is the major driving force behind the increased costs of the Medicare system. If Congress would alter the Medicare system so that reimbursement of medical care for the elderly were coupled with some types of means test, then demand for services would abruptly deflate and the cost of medical care and physicians' services would plateau.

Perhaps there is a justifiable need to reduce the costs of medical care in the United States. Curtailing surgeons' fees by a RBRVS will not accomplish it.

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RBRVS — An Internist's View

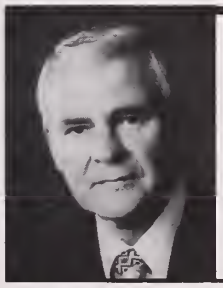
Much remains speculative as to the destiny of Harvard's Resource-Based Relative Value Study (RBRVS). There is dissension even in the ranks of primary care physicians whether or not relative values should reflect geographic location, i.e., practice costs and costs of living which so far are absent in the RBRVS. The AMA will receive input from state, county and specialty societies in November prior to taking a position at its interim meeting in December. Congress will hear this position as it will information from the Physician Payment Review Commission (PPRC), HCFA and organized consumer groups (AARP, etc.) prior to making a final determination as to whether RBRVS, in its present or some modified form, will be implemented and actually determine future physician reimbursement, at least for Medicare payments.

Other reimbursement options exist. Considering that Medicare payments for inpatient hospital services have increased 6% a year and physician payments 15% a year since the inception of PPS, we can be sure that some changes will occur. Options include a variety of expenditure caps, physician DRGs or capitation. If procedural physicians are concerned over ramifications of RBRVS, they should panic over the concept of capitation with primary care physicians as gatekeepers.

RBRVS supports a pervasive and long-standing impression that UCR payments perpetuate a historical reimbursement inequity in "cognitive" (listening, examining, diagnosing, prescribing, advising) services compared to "procedural" services. The study takes into consideration technical skills, physical effort, psychological stress, training costs, business expenses including liability insurance, etc., such as there is no contention that a one-hour encounter by a primary care physician should be equivalent to a one-hour procedure by a neurosurgeon. There will, however, be some leveling of the playing field that most analysts believe has been too steep.

Many factors determine a medical student's choice of specialty. When a GP finished his training after a one-year internship, compared to a four or five year surgical residency, there was a more understandable disparity in reimbursement, fostered by the advent of Blue Shield designed particularly for surgical procedures. With the explosion of medical knowledge most family practitioners cannot have hospital privileges without a three-year training program and many general internists have four or five years so the time in training gap has diminished. The same explosion of medical information causes a primary care physician's life to be highly uncomfortable. It is frankly easier to know a lot about a little than a little about a lot, further enticing physicians to subspecialty care. When the reimbursement table is tipped so steeply, especially when the bulk of physicians starting practice are deeply in debt, is it any wonder that there is a paucity of family physicians and many of the most prestigious residency programs in general internal medicine are not filling their slots?

The current perception of RBRVS is that a degree of sanity and fairness will be instilled into reimbursement to correct a disparity that has produced a perversion in the delivery of health care. Surgeons and all procedure-oriented physicians should be rewarded more handsomely for their consultations and examinations and diminish to some extent a force rewarding the emphasis on doing the procedure. Surgeons and medical subspecialists must understand that their status depends upon referral from the primary care physician, now in dwindling numbers. RBRVS, certainly not perfect in whatever final form it takes, will be vastly better than a number of more onerous options.



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The Harvard RBRVS: Is There a More Appropriate Relative Value Scale Alternative?

The sound and fury of enthusiastic supporters and distressed critics both prior to and accompanying submission of the report of the *first phase* of the Harvard Resource-Based Relative Value Study (RBRVS) for physician reimbursement has obscured the almost simultaneous completion of the *"experience-based" specialty RVS for radiology* which also has been submitted to the Physician Payment Review Commission and the Health Care Financing Administration (HCFA) to be implemented beginning January 1, 1989.

The genesis of this effort arose when the Reagan administration proposed to reduce Medicare expenditures in the federal budget for fiscal year 1988 by implementing DRG prospective payments for *all* physician services to inpatients. HCFA opposed that idea but suggested DRGs for only the specialty groups of radiologists, anesthesiologists and pathologists (RAP). As might be expected, this challenge was met by stalwart opposition by all of medicine which was successful on Capitol Hill in having this ill conceived, unworkable plan discarded by the Congress. It was also recognized that criticisms of the current customary, prevailing and reasonable (CPR) method of physician reimbursement was being increasingly perceived as inadequate and malfunctioning. CPR had been under severe, ever-mounting attacks and patchwork remedies had not resolved these criticisms, nor had the growth rate of Medicare expenditures for physicians slowed.

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Appropriate alternative ● It was felt by American College of Radiology leadership that since CPR would be under continuing seige, a better, more appropriate alternative than the RBRVS should be pursued. Distrusting the even then quite obvious problems that were emerging with Professor Hsiao's hypothesis and methodology of the Harvard Resource-Based Relative Value Study, the Congress was prevailed upon by the American College of Radiology, American Society of Anesthesiology, and American College of Pathology to support a constructive alternative — the concept of an *"experience-based" specialty RVS.* In hearings before the House Energy and Commerce Committee, these organizations were successful in having three separate experience-based specialty RVS plans introduced in place of the RAPs/DRGs in the House health bill. This was not easily accomplished. During and after the hearings bitter disagreement arose between the AMA and the RAP specialty groups which has been slow to subside. On December 22, 1987, the Congress passed into law and the President signed the Omnibus Budget Reconciliation Act of 1987 which provided direction to HCFA to develop these RVS in consultation with the specific medical organizations related to these specialties.

The legislation required the Department of Health and Human Services to develop the radiology RVS in conjunction with the Physician Payment Review Commission, American College of Radiology (ACR), and groups of other physicians who performed radiologic procedures. The RVS for radiology was due to be submitted on August 1, 1988 with fee schedules to be developed for implementation on January 1, 1989; the anesthesiology RVS guide by April 1989; and the pathology RVS in 1990.

The ACR was expected to collect and analyze data from its members on their performance of radiologic services. This monumental effort was undertaken under the leadership of Dr. James Moorefield of Sacramento, California, and a large committee composed of a broad cross section of radiologists providing services in diagnostic radiology, radiation oncology, interventional radiology, angiography, MRI, CT,

nuclear medicine, and ultrasound. Consultants in statistics, data collection, and economic analysis were also retained. Accordingly, extensive surveys of the membership of the American College of Radiology and other allied organizations have been carried out measuring several parameters. Specifically, professional component charges applicable to a hospital practice and global charges including both professional and technical components applicable to office settings were solicited from over 2,500 radiological practices in the United States. Over 700 charges were obtained for radiology services and procedures encompassing diagnostic, therapy, ultrasound, nuclear medicine, MRI, CT, angiography, and surgical procedures involving interventional studies. The charge survey provided a comprehensive up-to-date look at existing charges and provided information as to how these charges differed between types of practice and between practice locations.

Utilizing the intravenous urogram as a reference, the charge data was converted to a median RVS. This charge RVS formed the matrix for further development of the proposed RVS. Additionally, surveys were obtained of actual costs of radiologic practice; 900 radiological groups were questioned in depth concerning the cost for items such as labor, office space, supplies, equipment, and billing. The purpose was to identify variations of costs from region to region to form a measure from which geographic multipliers might be calculated and to assess the appropriateness of existing charges, particularly those related to expensive new services such as magnetic resonance imaging, computed tomographic scanning, and angiography.

A third survey of 2,500 practicing radiologists asked them to evaluate 57 separate radiological services as to complexity, time, and overall work involving those services, again comparing them to the reference intravenous urogram. This magnitude estimation survey of critical factors involved rating in five dimensions:

Mental effort and judgment
Technical skill and physical effort
Quality control and quality assurance effort
Possible harm to the patient
Overall complexity

This data was used as a measure against which charge data reasonableness could be assessed. Comparisons of charge data against the evaluations of complexity, time and overall work related to the tasks radiologists perform for their patients could identify significant discrepancies. Seven consensus panels of radiologists were convened and charged with the responsibility of comparing the charge data and critical factor survey data and reconciling the two based on their own judgment and experience. In order to constrain the panels from merely substituting subjective appraisals, written reports of decisions were required which had to be defended before the task force steering committee.

This methodology was utilized to avoid the criticisms of taking existing charge data and converting it into a relative value scale as merely perpetuating the status quo along with potential distortion that may exist with past payment patterns or other perverse market forces.

Thus by utilizing a very large data base of up-to-date charges and costs of varied geographic and practice settings in both hospitals and office practices and by consensus critical factor valuations, a realistic relative value scale will emerge that should be a more appropriate tool for valuing reimbursement for radiologic services to Medicare patients.

The problem of ambiguity in code description has also been addressed with the effort to be made of redefining code definitions, evaluating the possibility of elimination of some codes, and collapsing others so that a code and relative value means the same thing to everyone and can be applied uniformly.

This material has been completed and the data and an initial report have been presented to the Physician Payment Review Commission and the Health Care Financing Administration. The Health Care Financing Administration, in addition to the ACR's data survey, developed data from its own allowable charge data bank material. All of this material has been accepted and analyzed by HCFA and the resulting RVS is to be published momentarily in the Federal Register. It is anticipated that conversion factors and regulations for implementation nationwide will be determined by the intermediaries on a pricing locality basis initially, but eventually on a carrier-wide, statewide, or regional basis with transition to a more uniform national scale adjusted for geographic or practice differences. This RVS will reflect modulation in those relative charges that were either high or low in respect to the median relative value scale. The 1987 Omnibus Budget Reconciliation Act also required HCFA to reduce payment for radiological services by 3% over what would have been paid under the CPR method. The law also requires a national budget neutral level so that the conversion factors will have to maintain equity in fee schedules.

Incomplete study ● How should Florida physicians and the FMA view the report of the first phase of the Harvard RBRVS study?

Without any attention being given to valid concerns of methodology, extrapolation, cross linkage of specialities, statistics or preconceived hypotheses, the study is at present incomplete. The same legislation that mandated the experience-based specialty RVS ordered an extension of the Harvard Study to include additional specialties which were not involved in the first phase report. This is to be completed in October 1989. Any endorsement by any medical organization at this time would

seem to be untimely and premature. There is no legislation in effect to implement this study into law. Only by a considered analysis of the final report and access and review of the data can a valid judgment be made.

This first phase report which fueled the cognitive versus procedural arguments has only served to further intra and interspecialty divisiveness to the detriment of the entire profession. The AMA, while a subcontractor to the Harvard Study, has not endorsed the results of the study and should not offer any judgment until final completion and a detailed considered analysis is made.

Florida physicians have a significantly higher stake in this issue than most physicians since Florida has one of the largest populations of the elderly who are beneficiaries of the Medicare program. The responsibility for health care of this population is an awesome one which merits thoughtful consideration by all Florida physicians.

The implementation of the experience-based RVS for radiology and anesthesiology on January 1, 1989 should provide practical experience in the use of this methodology on a national scale long before the Harvard Study is completed and the Medicare program will have valuable real life experience which should be useful in guiding the profession, PPRC, HCFA, and the Congress in electing any further action.

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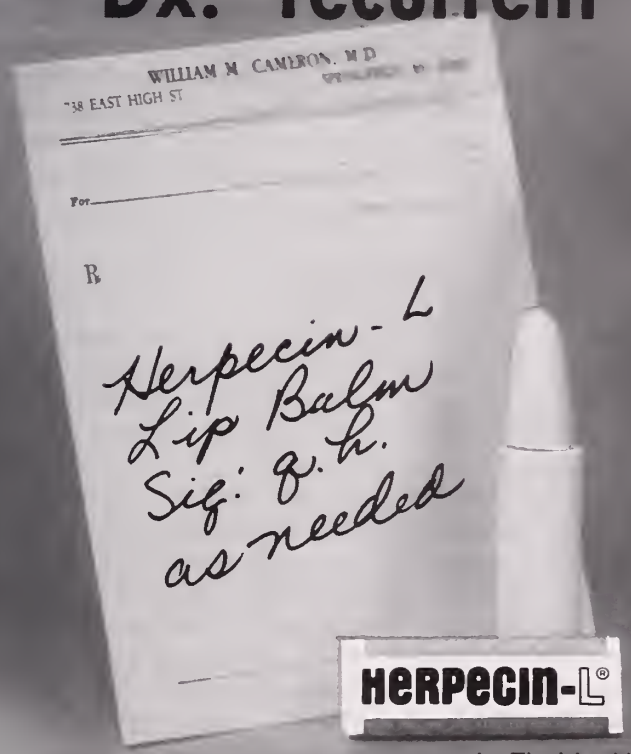

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Organized Medicine

Many years ago, March 1977 to be exact, the Capital Medical Society Newsletter published an editorial in which I considered the question as to whether or not medicine could still be considered a profession or whether it had become just another commercial enterprise. I concluded then that the transition was far advanced but that it wasn't yet irreversible. Now I wish to reexamine the issue in the light of another question. "Do we, as doctors, wish to be part of a Profession?" If so, can the characteristics of a profession be restored?

Considering our loss of autonomy in certification and discipline, the feet of clay exhibited by many of our colleagues, and the erosion of our ethical codes, it seems specious to argue that we are still a profession in the traditional sense of the term. In this era of high technology and high cost, I think it is questionable that we really want to be. And yet, we would like to be treated in such a fashion, and deep down, expect to be.

I think most students who select medicine as their life's work do so with more than a little bit of altruism and are willing to accept it as a way of life which is out of the ordinary and requires some sacrifices, but which also provides some unique rewards. However, too often these attitudes become corroded along the way to becoming a practicing doctor. The influences producing these changes are many and varied. They resist being categorized but all have a common characteristic of interfering with the respect, affection, and trust in the physician/patient interaction.

Having grown up in the golden years of medicine as a profession, it is hard to realize that it has not always received, nor deserved, respect and adulation. In the not too remote past, there was no pretense of professionalism. Medical care was practiced by individuals in guilds and crafts, and the care was characterized by superstition and ignorance. However, the potential for becoming a profession was always there because in almost all times there were giants of leadership who, recognizing that they were answering a nobler calling, always were inquiring, always searching for new knowledge and improvement in ways to care for their patients. Organization of groups permitted the sharing of information and the advancement of knowledge resulting in improved health of all society, as well as better care for individuals. Educational standards were established and nurtured by organized medicine. Its efforts insured the adequacy of physician's training and promoted the safety and effectiveness of hospital care. The motivation was always improved care for patients, and the result is the level of care which today is recognized as at the zenith. It is the result of organized not individual efforts.

Currently the FMA is launching an outreach program in an effort to get all Florida doctors into membership, and just as importantly, into membership in the AMA. Many may have what they believe to be good reasons not to belong but I believe that most of these reasons do not have good bases. I firmly believe it is in the best interest of each of us to belong, and I hope I can convince everyone.

Since WW II there has been an explosive fragmentation of medicine into specialties, each one having unique and limited interests and each ultimately forming its own restricted and limited organization. Because of their nature, these specialty societies naturally promote the special interests of their members and just as naturally don't care much about the special interests of any other group. The special interests are, more often than not, socio-economic and financial, and "for the good of the patient" protestations are too often translated into "for the good of my members". I encourage support for the specialty societies. They are needed; but give first allegiance to their parent. That is where we will live or die as a profession.

It is true that the FMA and the AMA also are portrayed as being more interested in the pocket book issues than those of moral, ethical, educational, and informational significance. The FMA has been mired in the quicksand of professional liability for most of the last decade, but that is more than a pocket book issue. On its outcome depends not only whether medicine can survive as a profession but even whether it can survive as a business. The activities of the FMA which are often overlooked or ignored are those which help to produce legislation designed to improve health care for the poor; the liaison and advisory roles to governmental departments and to legislative studies; the educational and communication services to its members through publications, forums, and meetings; and the insurance services it offers. Additionally, and

not the least important, are the services provided to members and the public in the form of peer review and arbitration of disputes through its grievance procedures.

The AMA is too often pictured as only a giant lobbyist which is against any health legislation that is designed to help people gain access to health care through government assistance. Everyone, doctors and laymen alike, should be familiar with the AMA publication "The Health Policy Agenda for the American People". The AMA took the lead in developing this study, resulting in its 1987 publication. It is a positive document, not a negative one. Also, on the national level, the AMA spends prodigious efforts to inform, communicate, and educate. It is instrumental in establishing standards in education, training, and other areas, and advises on propriety and ethics through the activities of its Judicial Council.

What I am urging is a reformatting, with primary allegiance to the parent organizations, county, state, and national. They provide our common bond. Let the specialty societies serve as the guilds, which they really are. Free up the AMA and the FMA to do those things which will restore our professional status. Then, when they present a program (or argue against one) based on the good of the patient, it will be clearly evident that it really is for the good of the patient.

Jim Conn, M.D.

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Superstar Ophthalmology A Modern Parable

Dr. Adam Alpha, a young, able, and ambitious ophthalmologist, wished to "do better," and he hired a consultant. The consultant recommended a three-part strategy. Adam should advertise his "differentiating points" (unique services and skills), "systematize" his practice (limit his activity to the "essentials"—namely, slit-lamp biomicroscopy and indirect ophthalmoscopy), and develop a referral network through contracted services or other practitioners, medical or not.

Fortuitously, Adam was approached by his community's hospital at about the same time. The hospital, with its own independent consultant, had come up with a strategy for providing eye services and presented it to Adam. Their consultant had concluded that they needed a "superstar." Because no such person seemed to be currently on the hospital staff, the consultant recommended that the hospital hire one. After an extensive search, it became clear that the hospital could not afford to recruit a suitable surgeon. The consultant then suggested that it create its own superstar. It was at this point that the hospital approached Adam to determine his interest in being their designated superstar. They proposed the creation of an Alpha Eye Institute, with staff support, guaranteed income, television and radio exposure, and an aggressive advertising campaign for cataract surgery and laser eye surgery.

Adam had questions. What would he advertise? Why would he do so? And what would be the effects? The answers of his own consultant and the hospital were essentially the same; they said, in effect, "Look, this advertising will cost a great deal of money. There is no point in advertising anything except relatively common services that will be highly remunerative to both you and the hospital." Ostensibly, both Adam and the hospital would be providing information in the public interest but when pressed for alternatives, the hospital administrators remained firm. They were interested in advertising "manageable care," specifically cataract surgery and laser procedures, and they wished to appeal to patients on the basis of the availability of these high-tech services. Adam's consultant and the hospital's agreed: the campaign should create an aura of "specialness," from which quality would be inferred; additional advertising should focus on services available only through Adam—particularly "new, improved" procedures.

Adam was not entirely comfortable, and he took time to consider the proposal carefully. What the hospital and his consultant proposed was the creation of a demand for services among patients whose symptoms or needs might not otherwise have led them to seek care. He was clearly being asked to approve advertising copy that he thought stretched the truth; the words were arguably supportable, but he believed his colleagues would disagree.

Adam considered the potential effects of the proposal further. He believed the suggested advertising campaign would increase his business. He also believed it would increase his costs and, to a degree, compromise his collegial relations in the community.

Close colleagues advised him that he would probably attract both the enmity and the jealousy of his competitors. He was told to expect the polarization of the medical community and limited communication with himself; he would be "frozen out" by many. As a result of this polarity and isolation, one colleague argued, there might be an overall decrease in the quality of health care in the community.

During his training, Adam had been exposed to phacoemulsification (ultrasonic lens fragmentation) but did not consider himself particularly skilled in this procedure. Both consultants believed that advertising space-age phacoemulsification with small-incision surgery was essential to create a "differential." Patients seemed to confuse such procedures with laser surgery, and the advertising campaign would purposely avoid dispelling this confusion. Adam sought proof of the benefits of this procedure, found some evidence of advantages and some probable disadvantages, and retained his skepticism about its long-term benefits. He consulted a colleague in another town who had performed phacoemulsification in the past and had abandoned the procedure after a careful trial. The colleague was now considering offering the procedure again, in response to demands from his patients. It occurred to Adam that he might be asked to shorten the evaluation time of new procedures of uncertain benefit in order to maintain his edge over his competitors.

Adam also considered the effect of his advertising on other ophthalmologists in the community. He believed that it would force them to advertise as well and that he could be caught in a cycle of advertising, clearly creating a profitable situation for consultants and related advertising firms but a less clear benefit to physicians and patients. If this was the consultants' strategy—and other ophthalmologists used similar tactics—his "superstardom" might prove to be evanescent.

Adam continued to be concerned about reconciling the needs of individual patients with the provision of appropriate information to the public. When he asked why information about glaucoma, amblyopia, diabetes, and macular degeneration would not be included in the proposed campaign, the focus of the plan became clear. This would be an expensive campaign, designed to make money for both the doctor and the hospital in which these diseases just did not seem to fit. Adam was unsure whether patients would be misled, but he believed that they would be attracted to him as a "superstar surgeon." He sought to understand which patients would be attracted by advertising. In speaking to physicians in other areas who had advertised, he came to believe that advertising attracted patients with relatively low educational and income levels, who were the most vulnerable to advertising.

Adam considered the potential costs of the proposal. Would such a campaign, designed to attract "consumers," create demand for marginal or even unnecessary services? Would demand for marginally indicated services increase the overall costs to government and other third party payers and ultimately to society? Would increased expectations on the part of patients lead to the proliferation of unproved diagnostic and therapeutic procedures? Would professional standards be lowered, in turn, with an ultimate loss of public trust in and deprofessionalization of ophthalmology? Would the need to differentiate his services from those of other practitioners increase his willingness to perform new and unproved procedures, and would the quality of the care he provided therefore suffer? If procedures in which he pioneered proved to be beneficial, would he be willing to share his advances or would he protect his "product"? If he were asked to share his expertise, would he be willing to describe his techniques to ophthalmologists in training or to other practicing ophthalmologists, thereby aiding and abetting his competition?

Adam was aware that reimbursement was at the core of the campaign, but he feared that his very success might have unwanted effects. In describing services, the proposed advertising would minimize procedures in an apparent attempt to reassure patients. But what if those who paid for the services truly believed his surgical procedures to be "safe, quick, simple, and painless"? Would they decrease his reimbursement?

Finally, he considered the likelihood of his achieving the success described by his consultant and the implications if all his colleagues acted similarly. Would the public believe all their claims? If they did not, would they question other things he said and recommended? Would this mistrust contribute to an adversarial relation—one of caveat emptor—with his patients?

Within days, the hospital administrators approached Adam again, this time with what they called an existing concept. The hospital had been approached by a health maintenance organization (HMO) with a large group of optometrists on salary and no ophthalmologist. They wished to join forces with the hospital in hiring the superstar. Their goal was to maintain control of primary care—including, in the case of eye surgery, certain aspects of preoperative and postoperative care for which the HMO would bill the patient or his or her insurer. The HMO provided bonuses to its staff on the basis of productivity, and reimbursement for perioperative care would be included in the calculations of bonuses to optometrists. Adam wondered whether he would feel compelled to operate on patients referred by optometrists for the extraction of cataracts when he believed the operation was not indicated. The president of the hospital was clear: "That's your business, Doctor. We expect you to maintain the highest standards of professional competence and behavior. After all, you are our superstar, and we expect you to behave like one.

And, by the way, we'd like your answer on this soon."

Over the past few days, Adam thought about the proposals. He sought the advice of his wife, who said, "The income projections certainly do appear attractive, but I sense your ambivalence." They agreed to consider the question in the morning.

He awoke early in the morning and took inventory of his situation: he had young children to educate; in his town, he would not be able to provide his children with an education and maintain the standard of living he desired; the world was changing, and he had better make hay now, while the sun shone; others were about to start similar practices in his area, and he might be left behind; his family had raised him well, to have high moral standards; he was strong enough to behave ethically in a competitive world; he really was capable of being a "superstar," given the opportunity; and if he was going to do this, he would not hold back—he would go for the entire program.

Promptly at 9 a.m., Adam called the hospital's president to accept the proposals, including the advertising campaign, the HMO network arrangement, and his new status. Said the president, "Adam, we appreciate the professional approach you have displayed in these discussions, and we wish you well. But, I'm sorry. You took too long to decide. We had to move on this, so we designated Dr. Eve Omega as our superstar. The campaign is underway. We're very pleased. She's so attractive and well-spoken. We just know she'll excel."

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Reprinted with permission from the *New England Journal of Medicine*, October 27, 1988.

The Patient-Doctor Relationship: Some Reflections on Retirement

I guess I've always believed that a special relationship exists between physicians and their patients. Certainly, at the conceptual level, I'm on record over the years in rhetorical support of the notion, writing about it in endless editorials and talking about it in tiresome trips to the microphone at reference committee hearings. And, not surprisingly, during some 38 years of practice, I've had occasion to be a part of many real world examples of the "ties that bind" patient and doctor—the joint sense of triumph when a very sick patient does well, the shared grief when a cherished one dies, the simple feeling of mutual trust that comes with solving problems together.

But all this had not quite prepared me for the events that took place recently. It started with my sending out in mid-April an announcement to my patients (everybody I'd seen professionally during the last three years) that I would retire from practice on July 1. The response was astonishing: an outpouring of telephone calls, of hastily scribbled notes, of lengthy letters, of formal store-bought cards, even some gifts (including a "lounging" robe and a gift certificate for golf cart fees).

The tone of these messages to Old Doc was mixed. Not infrequently, there was an undercurrent of anxiety, even of having been abandoned: "Where will I go now for medical care?" "Will my new doctor understand me as you do?" "Will I get those prescriptions you've always filled for me over the phone?" More often, the flavor of the message was sympathetic and congratulatory: "It's well deserved." "Now you'll have time for travel, for relaxing, to write that book you've been talking about." The most common sentiments expressed were affection and appreciation: "You were there when we needed you." "I remember your first office in the 1950s (there seemed to be a mild competition to see who could go back the furthest in time). "I recall you making a house call on a Christmas Eve when my mother had the flu and a temperature of 103°." "You have taken care of members of four generations of my family and we thank you."

Reality of the Relationship

With all this praise, one has to be careful to keep one's ego from expanding too much—and the way to accomplish this is by discounting. Remember the fact that more than half of the people you sent the announcement to didn't even acknowledge it? Remember all those people who used to come to you and who have deserted you for younger (better?) doctors? Remember that dreadful malpractice suit—from a presumably friendly patient? Add in the cynical truism that people are fickle, that a year from now your patients will have managed to establish a new relationship—and that their memories of you will dim.

But wait a minute. Those messages *did* come in, even if they were merely expressions of momentary sentiment. And the fact that so many patients took time to send those messages says something important about the patient-doctor relationship. The truth is that it *does* exist, no matter how fragile and transient it may be. That the relationship exists at all conveys a strong message about medicine: that it is still a profession rather than a trade. (Not one of my messages mentioned money.) The reality of the relationship says something that outsiders, particularly politicians and economists and planners, fail to take into account, and something that insiders, preoccupied with science and technology, too often overlook.

I'm sure that my experience is not unique, and that hundreds of doctors get similar responses when they announce their time has come to retire from the fray. I've written thank you notes by hand to all my well-wishers and plan to keep their messages together in a box some place. The thought occurs to me that if we could collect in one location *all* the messages sent to *all* physicians as they retire, we could probably fill a couple of warehouses with testimonials. And I would consider that real documentation—all right, it's anecdotal and not scientifically rigorous—about the true worth of the patient-doctor relationship. Just possibly, such evidence might help make a correction in the course that American medicine seems to be taking.

Anyhow, I for one am going to cherish my box of messages that came when I announced my retirement.

William Campbell Felch, M.D.
Rye, N.Y.

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Auxiliary Liaison Editor — **Mrs. Charles (Lynn) Moore**

The Auxiliary Federation: Two Views

How Important Is the AMA Auxiliary to Florida Auxilians?

The American Medical Association Auxiliary has unlimited potential, and the Florida Auxiliary is a major part of the overall picture. I am very proud to be a member of the AMA-A and the FMA-A and proud that auxilians are visible supporters of organized medicine.

AMA-A is a federated organization of counties and states working on common goals that impact on the quality of life in our communities. Auxilians working together on the county, state, and national levels implement strategies that affect and improve community health.

AMA-A and its member states work side by side with the AMA and state organizations to influence legislation on topics of critical concern to physicians and medicine. Our Florida Phone Bank, in conjunction with the AMA-A, has been very effective in alerting auxilians and physicians to activity in support of doctors and medicine for the good of patients. Three alerts were initiated by the AMA Auxiliary and the results were positive. We are fortunate to have dedicated auxilians and physicians who care and take the time to keep abreast of issues. Not everyone has the time or interest to be legislatively adept so we must depend on those who are. The Federation has many able members who work hard to keep us informed and who help us with lobbying for the good of medicine.

We are fortunate to have dedicated auxilians and physicians who care and take the time to keep abreast of issues.

Teamwork is the key which supports medical education. AMA-ERF raises money for medical students and medical school research programs. Our fund raising achievement represents a network of efforts on all three levels of the Federation. This combined effort results in millions of dollars donated to the Foundation which in turn is donated to the

Reflections on the Auxiliary Federation

Fifteen and a half cents a day give me the privilege of belonging to the Palm Beach County Medical Society Auxiliary, Florida Medical Association Auxiliary, and American Medical Association Auxiliary.

When I joined my county auxiliary, I had no idea of the magnitude of the health care programs provided to the community and to the medical family by the Auxiliary at the county, state, and national levels. The high quality seminars on personal and management skills, sponsored throughout the year by the AMA Auxiliary, are an enriching experience for those who attend.

The material presented benefits personal life as well as improves leadership skills...

In 1976 I attended my first Leadership Confluence in Chicago as president-elect of my county. For three days, starting at 7:30 in the morning and continuing until 9:00 at night, we were subject to an intense course on such subjects as effective writing, public relations, dealing with the media, and parliamentary procedure, just to name a few. I have never met an auxilian who attended who did not express the opinion that they had been to an extremely well-organized meeting. It is inspirational and uplifting. The material presented benefits personal life as well as improves leadership skills in service to the Auxiliary.

The National Auxiliary works with the state auxiliary to provide leadership training to members at the county level. In addition to teaching leadership skills, many programs are of particular interest to Florida auxilians such as adolescent health, drug abuse, substance abuse, AIDS education, and support groups

medical schools. AMA-ERF is the only national philanthropic endeavor of the AMA-A, and all auxilians can be proud of the results achieved by our unified effort. Florida has won many national awards for excellence in this area.

The National Auxiliary also provides direction for health projects across the nation. Although most of our work is done on the "grassroots" level, the impetus is a result of the AMA Auxiliary. Because of the many resources developed at the national level, county and state auxiliaries have access to a wealth of information.

The Project Bank, a national clearinghouse, has hundreds of auxiliary projects such as teaching breast self examination in high schools and drug awareness programs. Any county or state that wants a new project need not "re-invent the wheel." Projects are available free of charge and in full detail for implementation. Our Project Bank is the envy of many national organizations.

Because of the many resources developed at the national level, county and state auxiliaries have access to a wealth of information.

The National Auxiliary provides leadership training opportunities through the AMA-A Confluences at the annual convention and at state and county leadership training sessions. Florida can send 20 county presidents-elect per year to Chicago for the Confluence and the National Auxiliary pays the way. This leadership training has a very positive influence on the work of the Florida auxiliaries. Those who attend are stimulated by what they learn and are eager to share when they return home.

National leaders are available to visit state and county meetings to provide workshops and seminars. In addition, the AMA-A provides leadership tools including workbooks on communication, membership, leadership, and legislative action.

On an individual level, Florida auxilians may request brochures from the national office on teen suicide, sexuality, stress, pre- and postnatal care, drug use and abuse, keeping fit, drinking and driving, and child abuse. The cost of printing locally makes it difficult for counties to provide these materials to members, but the AMA-A provides them without charge.

Also, Florida members may take advantage of the AMA-A's Professional Skill Development Program. This is a computerized record of individual attendance at auxiliary seminars and of training for professional and volunteer advancement. A printout, without charge, is available to use as part of any resume.

As a member of the AMA-A, there are personal

for the medical family. National representatives are always available to visit local auxiliaries if needed.

National leaders are aware of the hard work done in the counties and are constantly updating programs to meet the needs of the medical community. As a member of the AMA-A Long Range Planning Committee, I am involved in discussions concerning the medical family on such subjects as Young Spouses (Children of the 60s); Spouses Working in Physicians' Offices; Career and Male Spouses; Foreign-Born Spouses; First and Second Year Members; the Retired Physician's Spouse; the Needs of the Major Metropolitan Auxiliaries; and the Needs of the Small Auxiliaries.

The American Medical Association, its Auxiliary and other state auxiliaries have been aware of the Florida Medical Association's petition drive to place a Constitutional Amendment on the November ballot which would limit noneconomic damages to $100,000 in civil lawsuits. As Chairman of the Constitutional Amendment Petition Campaign, I was thrilled to announce to the delegates at the AMA-A annual meeting in June that over 500,000 petitions had been collected (after two years of hard work by everyone), thus assuring the amendment a place on the November ballot.

The American Medical Association Auxiliary has over 70,000 members. It is conducted as a big corporation but has a small budget. Executive Director Hazel Lewis and her staff are so efficient that I am sure they could go into any failing business and put it back on the right track.

The American Medical Association Auxiliary has a tremendous amount of talented and qualified members willing to serve in leadership positions. I was especially aware of this when I served on the AMA-A Nominating Committee. Florida has never produced an AMA-A president, but many Florida auxilians have had the honor of serving on committees and holding office. I do feel that in the future we will have an AMA-A president from Florida because I know how talented our members are.

The American Medical Association Auxiliary has a tremendous amount of talented and qualified members willing to serve in leadership positions.

From my first time as a Florida delegate to the American Medical Association Auxiliary annual meeting in 1976 to the present, I still feel the thrill and excitement of the opening ceremony. I have such

AMA Auxiliary — *Continued*

benefits such as discounts on car rentals and hotel rooms as well as an opportunity for comprehensive member insurance. Each member receives FACETS, a magazine for and about physicians spouses, including topics of family concerns, socioeconomic issues, and health. Also available is "What Every Physician's Spouse Should Know," a series of booklets on topics of concern to the medical family.

How important is the AMA-A to Florida auxilians? The AMA-A is a special support system. It is part of a federation of good health, offering a "cafeteria" of benefits for its members, and stronger than ever before. We have made our marks on practically every health-related issue is recent times. Medicine cannot function alone in any community for medicine is part of a federated family on the county, state and national levels. The Florida Medical Association Auxiliary and the American Medical Association Auxiliary must work together to achieve our common goals.

Mrs. S. Bruce (Priscilla) Gerber
Winter Haven

Reflections — *Continued*

respect and admiration for the dedicated leadership of the AMA Auxiliary and feel proud to be a part of an organization that really cares about people.

The more I have become involved in the Auxiliary, the more I recognize the special qualities which members bring to the organization. The members are committed, organized, multitalented, educted, caring, and hard working, willing to meet the challenges of today. Auxilians stand ready to support the medical community. They understand the special problems of the medical family. Their friendship has enriched my life throughout the years.

For a little more than 15 cents a day, the best investment you will ever make is to belong to the Federation, your county, state, and national auxiliary. The question should never be "Why should I join?" but "How can I join?".

Mrs. V.A. (Susan) Marks
North Palm Beach

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BOOK REVIEWS

Book Review Editor — **F. Norman Vickers, M.D.**

Legal Guide for Physicians

by Joseph M. Taraska, price: $85. Matthew Bender Company, Albany, N.Y., 1987.

I have parked this book on my desk for over six months and have occasionally peered into it for guidance on some medicolegal matter or have read an occasional chapter when my curiosity has been piqued by its presence. I have never been disappointed. The book is a superb, succinct and clearly written exposition of law as it pertains to the Florida physician. It is a book that needs to be available to every doctor. Some of its chapters relating to the doctor/patient relationship, care and nourishment of medical records, and proper legal demeanor to be assumed when trying to recover from the initial shock on learning about the filing of a lawsuit should be required reading for every doctor. These chapters could be better grouped under the title, "The Legal Maintenance of a Medical Practice."

Mr. Taraska is a health law specialist and medical malpractice defense attorney in Orlando who lectures frequently to physician groups and contributed to the FMA Journal. He writes with authority but with a straightforward style that facilitates understanding by even the most legally obtuse readers, such as myself. His treatment of his subject seems quite complete as an introductory course on navigating the treacherous fjords of medical-legal law. He devotes a considerable proportion of the book to the nuances of malpractice suits but his manual contains many other useful items. He discusses the issues of hospital staff privileges and peer review. His section on informed consent is particularly useful. His book is stocked with sample documents of many types that should be incorporated into our patient and practice records.

An examination of this manual will uncover multiple potholes in our paperwork defense against the prolix demands of the legal system. I found that adherence to all of Mr. Taraska's recommendations would probably double my paperload and certainly overwhelm my present administrative staff. At least I know where my legal weaknesses rest so that I have the ability to fortify those areas that are particularly flimsy.

Jacques R. Caldwell, M.D.
Daytona Beach

The unprecedented increase in medical malpractice cases makes a physician's interaction with the legal system unavoidable. Whether a defendant in a trial or a witness in a case, going to court is a grueling experience.

Joe Taraska is one of the outstanding attorneys in Florida in defending medical malpractice lawsuits. His book is written in a way that allows a physician to easily find what his legal responsibilities to patients are and the legal consequences of decisions in respect to the doctor-patient relationship. It will help physicians understand what laws apply to their practices and effectively assist them and their attorneys if they face litigation.

The book offers a commonsense and easily understood approach to issues dealing with patients such as the doctor-patient relationship, including the obligation to accept patients and the appropriate way to terminate the doctor-patient relationship; disclosure of patient information, including the patient's rights to confidentiality and appropriate release of patient information, medical records, including the appropriate maintenance of medical records and the appropriate disposition of such records upon sale, retirement, or death of the physician; and medical consent, including consent generally and the issue of informed consent. All physicians face these issues from time to time, and they are presented in the book from a physician's point of view.

In addition to the practice aspects of dealing with patients, the book offers important guidance in respect to the physician's role in the legal forum. Here, such issues as the anatomy of a medical malpractice lawsuit, monitoring and assisting in the defense of a medical malpractice lawsuit, and the physician as a witness are dealt with clearly and concisely.

The book also deals with another important area, the doctor's relationship with the hospital where he practices. This particular chapter discusses peer review of hospital staff membership and clinical privileges, procedural due process, substantive due process and immunity.

This is one of the finest books written to date and will be a valuable asset to any physician's library.

John E. Thrasher, Esq.
Jacksonville

Meetings

Accepted by the FMA Committee on Medical Education for AMA Category I Credit

DECEMBER

Breakfast and Learn, Dec. 1, Doctor's Hospital. Contact: Lynda R. Colaizzi, M.D. (305) 549-6857.

Risk Management Seminar, Dec. 3, Holiday Inn Calder, Miami. Contact: M.P. Demos, M.D. (800) 431-3878.

Tutorial Courses of Instruction In Acute Cardiac Care, Dec. 5-10, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Gastrointestinal Endoscopy, Dec. 7-10, Buena Vista Palace, Lake Buena Vista. Contact: Worth Boyce Jr., M.D. (813) 974-2034.

Pediatric Cardiology, Dec. 8, University Medical Center, Plantation. Dr. Richard Zackheim (305) 662-8301.

Clinical Allergy & Immunology for the Practicing Physician, Dec. 8-10, Lake Buena Vista. Contact: Richard Lockey, M.D. (813) 972-7631.

First Annual Ocala Cardiovascular Day, Dec. 10, Ocala Hilton, Ocala. Contact: Rhonda Grubbs (904) 351-7206.

Risk Management Seminar, Dec. 10, Hyatt-Regency, Miami. Contact: Ronna Davis (904) 385-4935.

Basic Trauma Life Support, Dec. 10-11, Univ. South Florida, Tampa. Contact: James Hillman, M.D. (813) 251-6911.

Magnetic Resonance Imaging, Dec. 12-16, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Current Issues in Medicine, Dec. 17-24, Vail, Colorado. Contact: Sonja Craythorne (305) 547-6411.

Pediatric Care Network, Dec. 21, Miami. Contact: Dr. Nieves/Dr. Wurm (305) 549-7600.

JANUARY

Surgery of the Liver and Biliary Tract, Jan. 5-7, Alexander Hotel, Miami Beach. Contact: Duane G. Hutson, M.D. (305) 687-1367.

G.S. Wise Postgraduate Seminar of the Dept of Surgery, Jan. 5-7, Alexander Hotel, Miami Beach. Contact: W.T. Bouck (305) 687-1367.

12th Annual Oral Pathology Review, Jan. 7-11, Hyatt Regency, Miami. Contact: CME Department (305) 547-6716.

21st Annual Postgraduate Seminar in Adult & Pediatric Urology, Jan. 9-12, Intercontinental Hotel, Miami. Contact Charles M. Lynne, M.D. (305) 547-6630.

Seminar on AIDS and HIV, Jan. 10, Tampa. Contact: Unv. of S. Florida.

21st Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 10 & 12, Hotel Intercontinental, Miami. Contact: Victor A. Politano, M.D. (305) 687-1367.

Seminar on AIDS and HIV, Jan. 11, Clearwater. Contact: Unv. of S. Florida.

Pediatric Cardiology, Jan. 12, University Medical Center, Plantation. Contact: Dr. Richard Zackheim (305) 662-8301.

34th Annual Cardiovascular Seminar, Jan. 13-14, Manatee Civic Center, Bradenton. Contact: Melissa S. Crater (813) 867-5000.

Oculoplastic Update — 1989, Jan. 14-15, Good Samaritan Hosp., W. Palm Beach. Contact: Laura J. Lyons (407) 650-6236.

Magnetic Resonance Imaging, Jan. 16-20, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Diabetes Mellitus: Optimizing Treatment, Jan. 16-20, Jackson Medical Towers. Contact: Della Matheson, R.N. (305) 547-6504.

Topics in Pediatrics: 1989, Jan. 19-21, Lake Buena Vista Place, Orlando. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Pediatric Practice Problems in Dermatology & Emergency Medicine, Jan. 23-25, Good Samaritan Hosp., West Palm Beach. Contact: Laura J. Lyons (407) 650-6236.

Tutorial Courses of Instruction In Acute Cardiac Care, Jan. 23-28, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Visiting Professor Series, Jan. 24-26, Miami. Contact: Penny Ripple (305) 547-6411.

Arrhythmias: Interpretation, Diagnosis and Management, Jan. 27-28, Boca Raton Resort, Boca Raton. Contact: Deborah Wilderson (305) 798-9682.

8th Annual Perspectives on New Diagnostic & Therapeutic Techniques in Clinical Cardiology, Jan. 27-29, Walt Disney World. Contact: Registration Secretary 800-253-4636.

Critical Care Medicine, Jan. 31-Feb. 1, Sheraton Royal Biscayne, Key Biscayne. Contact: Dept. of CME (305) 547-6716.

FEBRUARY

Strategies in Critical Care — 1989, Feb. 1-4, Sheraton Royal Biscayne. Contact: CME Department (305) 547-6716.

Drugs for the 90's, Feb. 3-5, Colony Beach Resort, Longboat Key. Contact: Thelma Bassett (305) 284-7350.

A.S.P.E.N.'s 13th Clinical Congress, Feb. ??????, Fontainbleau Hilton, Miami Beach. Contact: Karen MacFirland (305) 587-6315.

15th Annual Vail Conference in Anesthesiology, Feb. 4-11, Vail, Colorado. Contact: Sonja Auzier-Craythorne (305) 547-6411.

Pediatric Nephrology Seminar XVI; From Old to New Frontiers, Feb. 5-9, Sheraton Bal Harbour, Bal Harbour. Contact: Pearl Seidler (305) 549-6726.

Obstetric and Gynecologic Options: Update Ultrasound and Laser Technology, Feb. 6-8, Good Samaritan Hosp, West Palm Beach. Laura J. Lyons (407) 650-6236.

Magnetic Resonance Imaging, Feb. 6-10, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Neurological Update — 1989, Feb. 7-11, Sheraton Bal Harbour, Bal Harbour. Contact: Univ. of Miami School of Medicine/Div. of Cont. Ed. (305) 547-6716.

Midwinter Seminar in Obstetrics and Gynecology, Feb. 9-11, Don CeSar Beach Resort, St. Petersburg. Contact: Betty Monti (813) 974-2088.

14th Annual Vail Symposium in Intensive Care, Feb. 11-18, Vail, Colorado. Contact: Sonja Auzier-Craythorne (305) 547-6411.

Cardiopulmonary Rehabilitation, Feb. 13-16, Orlando. Contact: Michael Pollock, Ph.D. (904) 392-9575.

Florida Thoracic Society's 11th Annual Pulmonary Wintercourse, Feb. 16-19, Contemporary Resort, Lake Buena Vista. Contact: Richard Doggett (904) 743-2933.

Pediatric for the Practitioner — Update on Intensive Care of Children, Feb. 17, Sheraton Tampa East, Tampa. Contact: Herbert H. Pomerance, M.D. (813) 974-4214.

Immunoconjugates Monoclonal Antibody Based Imaging, Feb. 17-19, Contemporary Resort, Walt Disney World. Contact: Dr. Aldo Serafini (305) 549-7955.

Current Status & Future Dir. of Imm. Mono. Ant. Based Imaging and Treatment, Feb. 17-19, Orlando. Contact: Division of CME (407) 547-6716.

Diagnosis & Management of Respiratory Diseases, Feb. 17-19, Sonesta Beach Hotel, Key Biscayne. Deborah Wilderson (305) 798-9682.

Eyelid Surgery: A Basic Course For the Practicing Physician, Feb. 18, Sheraton Grand Hotel, Tampa. Contact: J. Justin Older, M.D. (813) 971-3846.

14th Annual Review & Recent Practical Advances in Pathology, Feb. 20-24, Fontainebleau Hotel, Miami Beach. Contact: Marie Valdes-Dapena (305) 549-6437.

12th Annual Meeting of the American Society of Neruoimaging, Feb. 22-26, Grosvenor Resort Hotel, Orlando. Contact: Susan E. Syrstad (612) 378-7240.

University of Miami School of Medicine's Annual Conference — "Dementia; Current Research and Clinical Aspects", Feb. 24-25, Sheraton Bal Harbour, Bal Harbour. Contact: Raphael S. Good, M.D. (305) 549-7661.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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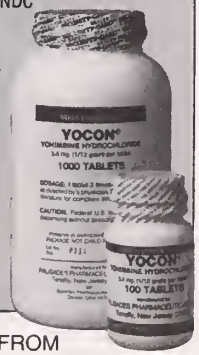

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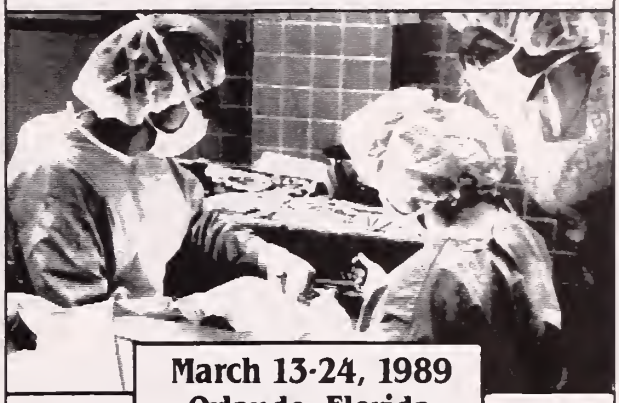

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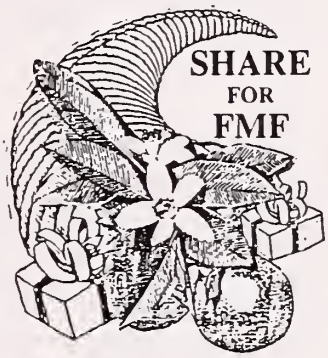

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Feature Editor — **Dale C. Havre, M.D.**

Socialized Medicine: It's Only a Matter of Time

The spectre has been hovering over our country for a long time. Some of us looking up have seen it; others have either ignored it or suppressed the image. It is there but no longer hovering. It is on the way down and coming fast. I am talking about The Big One—*Socialized Medicine*

As a profession and as a country, we have optimistically believed that the private insurance industry was somehow up to the task of providing affordable health insurance to enough citizens to ward off the threat of the government having to do it. After watching the latest round of premium increases and listening to spokesmen from the industry, however, I am convinced that private health insurance has shot itself in the foot so many times that Uncle Sam is going to put it out of its misery. The people, our patients, are going to mandate it.

Health insurance started out as a good idea. If everyone contributed enough money to the pot, there would be sufficient funds to pay for the medical expenses of unfortunate members of the pool who got sick. That was called "pooling the risk." The plan seemed to work pretty well for many years. Well people subsidized sick people, and the healthy ones were so happy they were well that they didn't mind paying the premiums. According to today's insurance executives, the concept is no longer viable.

Nowadays, there is a very different attitude among the health insurers. It seems to go like this: If we can't make money on you, we don't want you. If you're a poor risk to begin with, forget it. If you become a poor risk, even after you've been healthy and paid your premiums faithfully for years, we don't want you any more. Perhaps that sounds cruel and unfair; nevertheless it is the way the industry is evolving.

To illustrate this aspect of the health insurance industry, consider the latest move by one of the major health insurers in Ohio. It has begun to classify insured companies of fewer than 50 employees into two groups: those that don't have large medical expenses and those that do. For the latter, who are relegated to the "substandard category," premiums are going up astronomically. Instead of raising the rates for the entire pool and risking the loss of the "healthy" members to competitors with a lower premium, this insurer is hitting the "sick" ones right where it already hurts the worst—in the pocketbook. One unfortunate fellow, a diabetic with severe retinopathy, found his premium going from $370 to $722 per month. This is no longer insurance in my mind, not as it was originally conceived and intended. Since it would be entirely "legitimate" for an insurer to drop the coverage of the "undesirable" firms, and since it is unlikely that any other company would pick up the policies, then these huge premium increases must seem like extortion to worried individuals with health problems.

Apparently the practice of charging higher premiums to small companies in the substandard category is gaining momentum around the country. Even the spokesman for a coalition of small businesses is not sympathetic! Scott Lyon, group benefits manager for 5,200 companies in the Council of Smaller Enterprises, said: "They're (the insurance companies) trying to preserve their business." Wow! And just who is trying to preserve the health and resources of patients? Is the bottom line of "health" insurers taking precedence over the plight of sick Americans?

But even more discouraging is the statement attributed to William Silverman, official spokesman for Blue Cross of Ohio. In an interview by Doug Lefton, published in the October 10 issue of the *Cleveland Plain Dealer*, Silverman said: "Insurance is set up today to avoid insuring people with medical problems." If that is so, then who *will* insure the unfortunate members of our society who become seriously ill? After all, most of us are going to have a significant medical problem at some time in our lives. To whom will the concerned citizens of our country turn, when they can no longer count on private insurers to share the risk equitably or even to share it at all? Of course they are going to turn to the U.S. government for health insurance. In fact, they are going to demand it. And the way things are going, they are going to want it yesterday.

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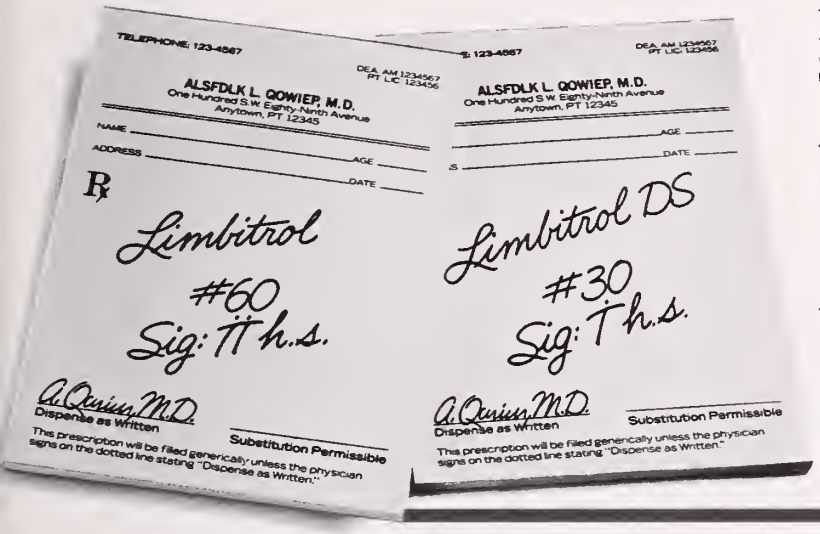

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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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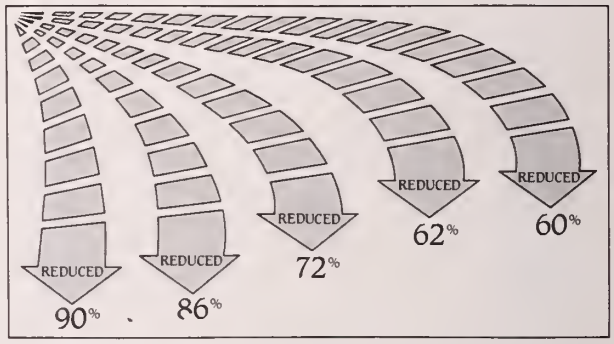

*Patients often presented with more than one somatic symptom.

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Holiday pageantry lights up the skyline of Jacksonville, scene for the 1989 FMA Leadership Conference on February 3-5. With the theme "Excellence in Leadership," the conference is fitting reminder of our organization's accomplishments in 1988 and a welcome prelude to the new year. On that note, the staff of *The Journal* wishes you and yours a joyous holiday season.

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References:
1. Martines C: Comparison of the prophylactic anti-anginal effect of two doses of Nitroderm TTS in out-patients with stable angina pectoris. *Curr Ther Res* 1984;36:483-489.
2. Brady EM, Gold OG, Rosenbach H: Transdermal nitroglycerin antianginal comparative trial involving oral nitrates: The Transderm-Nitro A.C.T.I.O.N. Study. Presented at 2nd Cardiovascular Pharmacotherapy International Symposium. San Francisco, October 1987.

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EDITORIALS

Quitting When the Fun Is Gone

The unexpected retirement early this month of a medical colleague made me reflect on the uneasy state of medicine today.

At 57 and in good health, with a thriving surgical practice, and with a solid reputation in the medical community, why would a physician like this choose to retire at his prime? He still loves medicine, he said, and that's what hurts most. But he could no longer stomach what has been happening to his profession, and then he started reciting the usual litany of problems: the increasing bureaucratic hassles, the loss of autonomy for physicians, the commercialization of medical practice, the changing physician-patient relationships, and, most of all, the onerous malpractice climate along with the $4,000 he doles out for his monthly premiums. He was hoping, like most of us still do, that things would get better—but, of course, they have gotten only worse.

Like many physicians in my community, I feel saddened by the premature retirement of someone who has served his profession honorably and who has so much more to contribute but cannot do so now because of circumstances beyond his control. He took care of his patients with extreme competence and compassion, he served as the president of his medical society, and he set high standards of probity and integrity in his practice. How shameful that he had to leave his profession long before he had to do it.

My colleague's case, of course, mirrors a growing national trend: physicians opting to retire early because of increasing dissatisfaction with what they are doing. Practicing medicine, it appears, is no longer fun for many physicians. The joys of medical practice so memorably captured by Norman Rockwell have been replaced by the burdens of an ever-increasing maze of regulations, daily hassles with nincompoops from everywhere, bureaucratic ineptness, a growing skepticism by patients, and threats to the independence of the physician.

Another colleague summed up the pent-up frustrations of physicians with the rhetorical question: why not just impose socialized medicine to spare the profession the agony of a slow and painful castration?

Through my medical schooling, residency training, and early years of medical practice, I have been impressed by the fierce pride and special attachment of physicians for their profession. Very few retired early except for disability and a few other compelling reasons; most, in fact, practiced into their 70s and 80s or until they felt they could no longer competently care for their patients. But, alas, they will become but a relic of the past.

The loss of many physicians through early retirement ultimately victimizes the public. Even considering the surfeit of physicians, the loss of certain vital medical services is hard to replace. The relative paucity of neurosurgical and obstetric services in many parts of the country, for example, is a classic illustration of this perverse situation.

Politicians and policymakers obviously do not have much sympathy for physicians as long as they are able to squeeze every drop of blood from them. It is ironic that in a country that prides itself in having the best system of medical care in the world, many of its physicians are increasingly getting restless and disillusioned. When one considers the 11 to 15 years that it takes to train a physician, along with the expenses and the years of practice during which skills are further honed, it in unconscionable that we would allow this medical brain drain to happen. A government incapable of recognizing that it is draining many of its talented citizens from their occupations does not think much of the public weal.

The growing dissatisfaction within the ranks of medicine does not bode well for a profession that has already been gutted by the steadily declining pool of applicants to medical school. Even though most of us still feel we love medicine, even though we are continually implored by medical school deans to spread the gospel of our profession to young men and women, it will be a hard job to do knowing well that things are not what they used to be. The thinning ranks of medical school applicants also mean that the quality of future physicians may not be comparable to what we have now.

The stability of a profession depends, among others, upon how its members feel about the future of their calling. Against the current backdrop of growing dissatisfaction, restlessness, and early defections by physicians, it will be a long, dark journey into the night for medicine.

R.G. Lacsamana, M.D.
Editor

Is a Split Inevitable?

The recent unveiling of the Harvard Resource-Based Relative Value Study has brought several issues into focus. The first one is the question of whether the present Medicare reimbursement system should be overhauled. There has been much discussion on this subject over the past few years as it has become apparent to many that the system is unwieldy, inflationary, and inequitable in many cases. Of course, as an internist, I welcome the conclusion that primary care specialists are underpaid and procedure-oriented physicians overpaid. At the same time, I realize that there will be other points of view, some of which may be acrimonious, divisive and end up creating rifts in medicine which may be irreparable.

As I read the conclusions of the Harvard Resource-Based Relative Value Study and comments by procedure-oriented and cognitive specialists, I came to believe that a difference of opinion among medical specialties may be inevitable and that the practice of medicine has become so specialized and so different among the specialties that it will be very difficult for one organization, i.e., American Medical Association, to speak effectively for medicine.

As I pondered on this topic, I realized that if this were the case, than it represents a watershed in the medical system of America and a point from which there may be no return to the past. Since the inception of organized medicine in the late 19th and early 20th centuries, the AMA has spoken largely as a collective voice for American medicine, although there have been times when various groups have felt that they must protect their own interests and have stepped outside its collective arms. However, the majority of physicians in whatever specialty have been content to let the AMA and state medical associations speak for them. This, of course, has been somewhat tempered by those physicians who have opted not to join the AMA or the state medical associations. Presently, in Florida, there are about 7,000 active practicing physicians who do not belong to the Florida Medical Association and a much greater number who do not belong to the AMA. The reasons are varied and if you asked each of them, I am sure you would get numerous reasons ranging from monetary to the feeling that the state or federal organization does not represent the views of the respective physician. However, regardless of the fact that a substantial number of physicians do not belong to either state or federal organizations, the fact is that the AMA has remained largely the voice of medicine in the United States.

The findings of the Harvard Study may indicate that this is no longer the case. It may also indicate that this is a belief which has occurred slowly and without purpose on the part of many specialists who now feel that their specialty society is better equipped to speak for them. The number of physicians who belong to specialty societies has increased substantially. The Harvard Study shows that the interests of the various specialties have grown apart and it may be very difficult for anyone to speak collectively for doctors in the United States. This may be inevitable with the growth of specialization and the ethical, moral and economic pressures that are now involved in medicine, but it is also sad. If organized medicine no longer has one collective voice to speak for the majority of physicians, then I feel that many of our causes will be diluted and lost as each one fights for his own parochial spheres of influence. The Harvard Study simply brought this to a head; it has been developing for years with various specialty societies negotiating with the federal government on their own in order to work out payment systems that would be most beneficial to that specialty. Of course it is perfectly understandable that this would be the case when one's financial status is about to be substantially altered. The Harvard Study, if it were to be enacted, would dramatically alter negatively the economic status of some of the specialties in this country. We could logically expect that they would resist this movement.

It must be pointed out that the AMA has not taken a stand on the Harvard Study but has said it is going to study it closely. The AMA is certainly aware of the divisiveness that this report could have within the ranks of medicine. However, reality dictates that some change in the reimbursement system of Medicare is going to come about. The federal government is no longer going to sit idly by and not propose sweeping changes when the percentage of the gross national product is steadily creeping upward with a larger proportion of the federal budget being spent for medical care. This is inevitable. What that change will

take no one knows. It may be adoption of the Harvard Relative Value Scale or an amended version, or emphasis on prepaid payment plans, which the Reagan administration and William Roper, head of HICFA, seem to favor, or a mulitude of other plans which may emanate out of Congress. In any event, all of these will impact heavily on the various specialties and we can be sure that each will fight for its own turf.

Is there any way that the AMA can come out of this rapidly changing sociological and economic evolution and still continue to be the spokesman for the bulk of physicians in the United States? The answer is unknown at present. It will be a very difficult task. The interests of the various specialties may have come to the point that it will be impossible to arrive at a common denominator for the AMA without irritating various factions and losing its effectiveness. There are many who feel that the AMA will have to take a stand based on the best course concerning medical care for Americans and what the government can afford. Upon deciding what path this is, it will then have to pursue this course, recognizing that some specialties will probably be alienated and members will turn to their respective societies for representation. Apparently there will be no middle road. To try to satisfy all factions will be to antagonize not only the different specialties, but also the American public, which is the long run would be more detrimental and more destructive.

Of course the logical question that could be asked is: What is the right path for the AMA regarding the health policy and health care of the citizens of this country? I admit that I do not have the answer, but I think it lies somewhare in the various proposals that have been put forth. It lies within the different ideas that Congress is proposing and within the wishes of the American people. They will determine what type of medical care they wish and how much they are willing to pay for it. It is obviously a difficult job to take all these factors into account and decide what should be the proper course of action for any organization proposing to speak for medicine.

I think, however, that this is the only way the AMA is going to maintain viability and respect not only among the majority of physicians but also among Americans who after all determine whether its guidance will be accepted or not.

H. Frank Farmer Jr., M.D., Ph.D.
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LETTERS & VIEWPOINTS

Florida Doctors Must Pay Sex Tax

Massachusetts has been euphemistically called Taxachussetts because the residents of that state have the highest tax burden in the United States.

This high tax burden has caused a migration of people from Massachusetts to southern Vermont and New Hampshire. This indicates that when taxes reach an oppressive point, people will rebel, and move to a more favorable environment.

Doctors practicing in Florida are not only burdened with the taxes of other Floridians, but also pay a large hidden tax called malpractice insurance. This is a substantial tax which can be as high as $100,000 per year. In reality malpractice insurance is a tax fund for insurance companies and attorneys who benefit the most from the malpractice tax.

Even though the tax burden is unbearable, the Florida legislature is squeezing more blood from the stone in the form of a doctor's SEX TAX. This tax is the epitome of absurdity.

The state of Florida has few restrictions on sex. Therefore, junkies, alcoholics, and heavy cigarette smokers have no sanctions on sex, and there is no law which makes these individuals practice birth control. Unfortunately sexual activity in these women result in the production of babies with a high rate of birth defects. Someone must pay for the management of these unfortunate newborns. The Florida legislature decided that a fund should be set up to pay for these babies; and their mothers should be compensated.

This fund will not be financed by a tax on the drug pushers, alcohol companies, or cigarette manufacturers. This fund will be derived from a SEX TAX on doctors who unfortunately chose to practice medicine in Florida.

Starting January 1989, all doctors must pay a $250 SEX TAX in order to obtain a license to practice medicine in Florida, whether or not the doctor treats or delivers babies. Those doctors who deliver babies must contribute $5,000 to the Florida Sex Fund.

The money from this fund will be given to mothers who produce a deformed baby. If the fund is not sufficient to pay for all of the deformed babies, then the doctors will be assessed additional tax.

Taxation without representation was responsible for the Boston Tea Party. Taxation without representation caused the Revolutionary War. Excess taxation is causing people to leave Massachusetts in droves to live in New Hampshire where the license plate motto reads "Live Free Or Die."

The Sex Tax will cause doctors to leave Florida and find a place where they can "Live Free (from taxation without representation) Or Die."

J.N. Brouillette, M.D.
Winter Park

Toward a New Agenda

Two years ago in these pages I predicted that doctors versus lawyers was a contest we would lose. We lack the skills, will, contacts, resources, and gall to best the legal profession on its turf. This is reality and, perhaps, we should even be proud that we are not so skilled in the rude arena of media manipulation. We should not take pride in our defeat, however, nor in our continued failure to understand the degree to which we have lost the public's confidence. Relief from the various ills affecting medicine cannot be expected from a particular law or legal maneuver. Rather it will come from the cumulative impact of many actions taken independently by our profession and the subsequent slow but steady perception by the public that we have put our own house in order.

Realistically, what can we do right now to improve things? First, we need to stand firmly for effective peer review. If we are consistently providing high quality care then let's prove it beyond doubt. We cannot prove it today and obviously our patients, neighbors, and the legal profession know it. The fact that substantial difficulties stand in the way of effective peer review is not an excuse.

Specifically this will involve support of studies in every specialty and in every region so that current patterns and standards of care are more widely recognized. It will require a willingness to tackle the difficult questions which will arise when the standard of care is controversial, expensive, or in constant evolution. It will require us to embrace the concept that peer review is an activity we perform willingly because we want to give our patients the best possible treatment. This is more than committee work and chart review; it is a public commitment to give our best and not accept anything less. Quality of care can be studied, measured, and improved, and we are the ones who ought to do it.

Second, we need to abandon single-issue political battles. Regardless of the merits of our case it is still too easy for skilled opponents to distort the truth in a single campaign. We need to be perceived as a trusted profession, not a self-serving political action committee.

Third, it is time to become financially more sophisticated. The money squandered in recent campaigns regarding the liability issue could have been used more effectively in less glamorous efforts to educate the public and the legislature regarding medicine's limits. We are so quick to trumpet the successes, and so often the recipients of public irritation over rising costs and confusing bills. We are all frustrated with various bureaucracies but as yet still in the earliest stages of more effective response to third party involvement in day-to-day medicine. Let's not hire any more consultants or pollsters, but rather concentrate on making steady gains in areas where we can and should make progress. As a corollary, if we cannot give up consultants and pollsters let's at least get the same ones the trial attorneys use.

Frustration over the big picture should not cause us to abandon efforts to change things. But it is time we turned to an alternate agenda to achieve our goals.

Stephen Sandroni, M.D.
Jacksonville

A Peace Corps for Lawyers

It strikes me as strange that a national election and change of power in this and other civilized countries can take place without strikes, riots, revolution or other forms of violence. Yet, in the third world, violent overthrow of the established government seems to have become the norm. I have pondered this dichotomy for many years and believe I have discovered the cause and the solution.

The problem with the people of the third world is that they do not have adequate means of resolving conflict or disputes without violence. In the civilized world, we do not kill each other, we litigate! The rest of the world does not have enough lawyers to go around to litigate all the disputes. As we in this country have more attorneys than the rest of the countries in the world combined, we are obligated to come to their rescue by sharing our surplus.

The precedent has already been set for drafting a specific segment of society and excluding others. For years after the universal draft ended, young physicians were still drafted into military service. What I propose is a draft of all graduating attorneys to serve in a New Peace Corps, a peace corps made up of bright young attorneys who will go all over the world, and teach the savages to litigate as we do, instead of fighting. Certainly a few of them may perish, but we have more than enough to go around, and the future supply seems to be limitless. Probably also some of the older barristers would volunteer to lead these Troops for Peace.

Think about it, then write your congressman!

John F. Mason, M.D.
Panama City

Amendment 10: The Morning After

Standing at the polls on election day, politely begging support, provided me with a broader perspective on Amendment 10. Occasionally comments would be offered or questions asked. There were at least two pervasive negative attitudes that I seemed to detect.

Obviously the public did not want to give up its right to sue for unlimited amounts. Even when no negligence or fault is involved in an injury, people want to recover sums that will inflict a Procrustean punishment. The attitude, though possibly perverted, is understandable: "If fate should dare frown upon my life, someone must pay." And, in fact, the public would seem to have a better chance at winning the legal lottery than the state lottery. If the occasion arises, they just want to win big.

Secondly, it became evident that lawyers are not held in high esteem, but that no love is lost on the medical profession either. We are still viewed with envy. We are still looked upon as fat cats. We are still seen as self-serving sycophants unwilling to clean up our own supposedly dirty house. We certainly did not engender much supportive sympathy.

We lost. Now the question is why and what can we do to better our position. In a future Journal issue, I would like to see a demographic analysis of the vote. Was there a geographic difference in the vote? Looking at median incomes from various precincts, did economic groups view the question differently? Unfortunately the battle was perceived only as the doctors against the lawyers. Was there vocal support from anyone else? Where were our strengths and where were our weaknesses?

Furthermore, and of great importance, there should be a full accounting of how our funds were dispersed. How much went into the entire campaign? How much came from physicians? From where did we acquire additional support? How were the dollars distributed across the state? How much went to consultants? How much went into the printed media and what portion went towards TV exposure? Although

we all recognize the need to financially back our political views, sometimes assessments seem to be arbitrary. To reassure the membership, be open and be certain that there is complete disclosure.

Finally, I would like to see suggestions as to where we go from here. Personally, I feel somewhat spent and a little abused, but the matter must be pursued.

R. Donis, M.D., D.D.S.
Altamonte Springs

A Challenge to the Big Counties

In the October 1988 edition of the Journal was a letter by Dr. Henry Glick, an obstetrician, obviously from the Miami area. He, of course, described the difficulties encountered by the obstetrician in Florida in today's legal atmosphere.

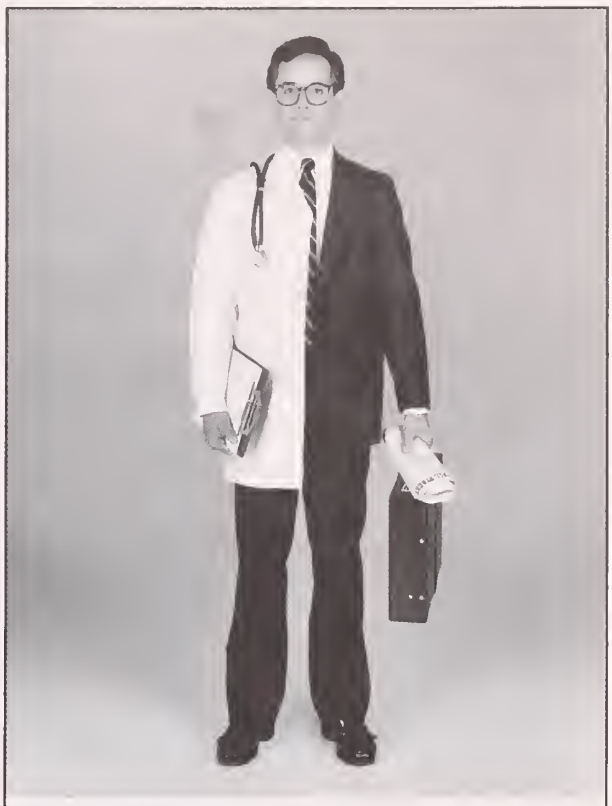
I would like to express, of course, sympathy with his position, but I feel that's as far as it can go. In the recent campaign to accomplish passage of Amendment 10, Dade County was far from supportive. In the period when we were attempting to obtain sufficient signatures to place the amendment on the ballot, Lee County with its population of some 250,000, obtained 30,000 signatures. Dade County, with its population in the millions, obtained approximately 8,000 signatures. This, to me, demonstrates a marked apathy on the part of the medical society of Dade County.

In the final voting for Amendment 10, Lee County passed the amendment by a count of 57% to 43%. Collier County and Glades County in Southwest Florida also passed the amendment. On the other hand, Dade County, Broward County and Palm Beach County did not pass the amendment.

Until the more affluent side of the State of Florida and by this, of course, I'm referring to the East Coast, unifies and becomes more than egregiously apathetic, I doubt very much if we will ever have tort reform in the State of Florida.

This may be taken as a challenge to those who were unable to muster the cooperation to accomplish the task, but I doubt very much if they will be perceptive enough to accept it.

John B. Fenning, M.D.
Fort Myers



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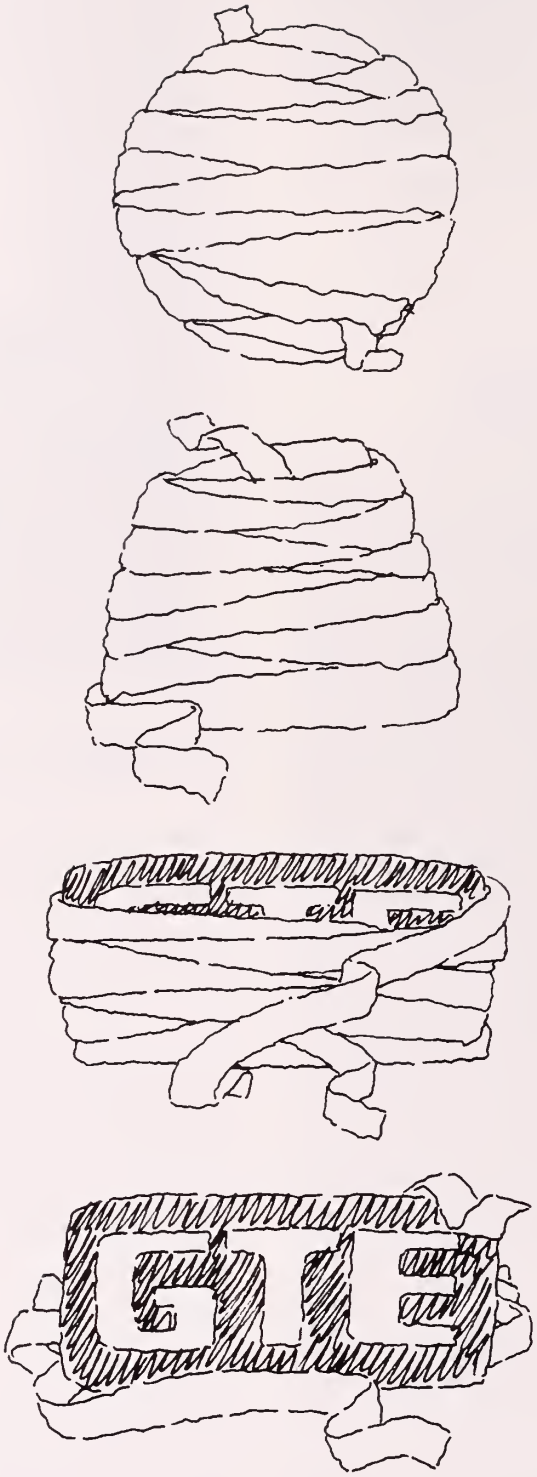

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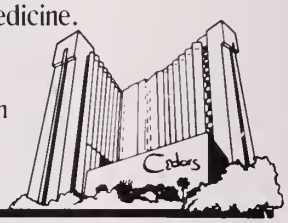

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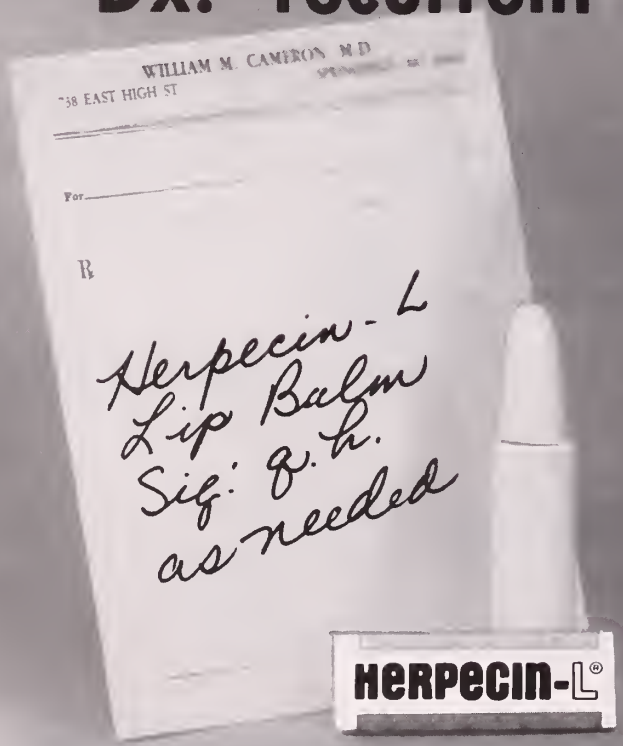

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TABLETS

BRIEF SUMMARY
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INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes.*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General: As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Quinolones may also cause anaphylactic reactions and cardiovascular collapse. Anaphylactic reactions may require epinephrine and other emergency measures.

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions: Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients: Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C: Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg q12h
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg q12h
Urinary Tract*	Mild/Moderate	250 mg q12h
	Severe/Complicated	500 mg q12h
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg q12h

Nursing Mothers: It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

Allergic reactions ranging from urticaria to anaphylactic reactions have been reported

SPECIAL SENSES *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

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DECEMBER 1988 • Vol. 75 • No. 12

Cervical Human Papilloma Virus Infection: Is Treatment Possible?

Guy I. Benrubi, M.D., John Shannon, M.D., Jeffrey Glazer, M.D., and Robert C. Nuss, M.D.

Editorial Comment: There is no question that the emergence of Human Papilloma Virus infection of the female genital tract has become very evident in the general population. While it is true that the majority of infections seen clinically occur in young women, the disease process affects all age groups. I would dare to say that in many practices at the present time, HPV infection is encountered as much or more often than other sexually transmitted diseases.

This article makes the important point that treatment for HPV infection of the female cervix is, indeed, not only elusive, but perplexing. Certainly, other clinicians are experiencing the same problem with treatment of patients having abnormal pap smears secondary to HPV infection who fail to respond to the currently accepted modes of therapy. With such high failure rates, I believe that even with the best education patients will expect some form of cure once therapy is instituted. If therapy is instituted and follow-up pap smears continue to be abnormal then the patient's expectations of cure will not be met. I feel that it is very important that the clinician not make false promises concerning treatment and cure rates with this disease and that every possible precaution pertaining to patient education about HPV infection be undertaken.

I commend the authors for elucidating a very important and significant clinical concern that faces all of us who practice gynecology.

Pierre J. Bouis Jr., M.D.
Contributing Editor, JFMA, Tampa, FL

***ABSTRACT:* Human papilloma virus (HPV) has been identified as the most likely precursor infective agent leading to cervical dysplasia. Effective treatment is still being sought for HPV infection of the cervix. This study evaluated three treatments: laser vaporization, cryotherapy and topical application of trichloroacetic acid. One hundred fifty women with biopsy proven cervical HPV infection were randomized to these treatment modalities. Medical records where available for review for 106. Failure rates, defined as abnormal pap smears after treatment, were 70% for trichloroacetic acid, 44% for cryotherapy and 50% for laser vaporization. Efficacious treatment is still elusive for HPV infection of the cervix.**

The Authors
GUY I. BENRUBI, M.D., JOHN SHANNON, M.D., JEFFREY GLAZER, M.D., ROBERT C. NUSS, M.D.
Dr. Benrubi is Associate Professor, Division of Gynecologic Oncology, Department of Obstetrics and Gynecology, University Hospital of Jacksonville, Jacksonville. Dr. Shannon is a Resident Physician, Dr. Glazer, Attending Physician, and Dr. Nuss, Professor and Division Director.

The human papilloma virus (HPV) is a small nonenveloped DNA virus of the papovavirus group.[1] Its ability to integrate into host DNA has been established.[2] Two subtypes, 16 and 18, have been found in 40% to 70% of invasive cervical cancers. This has lead to speculation that the virus can act as an oncogene and trigger cervical dysplasia.[3] Treatment of infection may, therefore, prevent development of cervical cancer.

Current treatment of cervical HPV infection is by the use of cytotoxins such as trichloroacetic acid (TCA) and podophyllin; vaporization by the CO_2 laser; cryotherapy; and interferon.[2] This study was designed to determine the effectiveness of TCA, laser vaporization and cryotherapy in eradicating HPV infection of the cervix. Two preliminary studies completed in this institution demonstrated that both laser vaporization and cryotherpay had an 80% efficacy rate.[4,5]

Materials and methods • From August 1985 to December 1987 women with biopsy proven HPV infection of the cervix were randomized to either a TCA, cryotherapy or laser vaporization protocol. These patients had been referred to the University Hospital of Jacksonville, Florida, Dysplasia Clinic for investigation of an abnormal pap smear. Eighty-four percent had Class II pap smears. All had colposcopical directed biopsies. Those women with biopsy proven HPV of the cervix were randomized by computer table. Excluded was any patient with dysplasia in association with the HPV infection.

Patients placed in the TCA arm had two applications of 50% TCA to the cervix one week apart. The TCA solution was applied until blanching of the entire cervical portio was seen. The women randomized to cryotherapy had one course of nitrogen gas cryotherapy. Two 30 second freeze, 30 second thaw

cycles were performed. The laser therapy group had CO_2 laser vaporization of the cervix to a depth of 7 mm. The complete transformation zone was ablated.

Follow-up consisted of pap smears every three months. The first pap smear was performed three months after treatment. Two Class I pap smears were defined as a cure. An abnormal pap smear with HPV on colposcopic biopsy was considered a treatment failure.

Results ● One hundred fifty women were randomized in the study; 106 (70%) of their medical records were available for review: 40 in the laser group, 34 who received cryotherapy and 32 in the TCA protocol. Twenty five of the 32 in the TCA arm completed two courses of TCA application. Follow-up was 40% for the TCA group, 47% for cryotherapy and 30% for those receiving laser treatment (Table 1).

A treatment failure was a Class II or greater pap smear after therapy was completed (Table 2). Seven of ten (70%) patients in the TCA treatment arm who had follow-up had a Class II pap smear at the first post-treatment examination. Four of the seven received no further treatment and were lost to follow-up. Two received additional cryotherapy treatment. One of them was lost to follow-up and the other had a Class II pap after cryotherapy. The final patient was secondarily treated with laser but did not return for further examination.

Table 1

	Enrolled	Completing Therapy	Follow-up
TCA	32	25 (78%)	10 (40%)
Cryotherapy	34	34	16 (47%)
Laser	40	40	12 (30%)
Total	106	99 (93%)	38 (38%)

Table 2

	Fail Rate	
TCA	7/10	(70%)
Cryotherapy	7/16	(44%)
Laser	6/12	(50%)

Seven of 16 (44%) patients treated with cryotherapy had subsequent Class II pap smears, detected at the first posttherapy examination. Two of the seven patients had no further care. One had a second cryotherapy treatment but no follow-up pap smear. Three underwent laser ablation; one had persistent Class II paps and two had no further pap smears. The last patient in this group had a total abdominal hysterectomy.

Of the 12 women in the laser protocol who returned for follow-up six (50%) had subsequent Class II pap smears. Three of the failures occurred after initial Class I follow-up pap smears. None of these patients had any further therapy.

Discussion ● All three methods of treatment in this study had high failure rates. While cryotherapy has the lowest rate of failure, the low power of this study does not allow the conclusion that it is the method of choice. However, since the cost of cryotherapy is much less than laser, it can be concluded that it should be the first-line treatment modality for cervical HPV infection.

Ferenczy et al reporting the investigation of cervical HPV infection treatment failures concluded that latent infection in colposcopic normal appearing tissue is responsible.[6] The incubation period for HPV is one to eight months.[2] Since the majority of failures in this study occurred at the first posttherapy examination activation of latent infection and not reinfection seems the most likely etiology.

Increasingly investigators are coming to the conclusion that eradication of HPV infection of the lower genital tract is elusive. A trial of very radical laser vaporization of the total lower tract including cervix, vagina, vulva, perineum and perianal area reported at the Society of Gynecologic Oncologist's Annual Meeting[7] resulted in a greater than 90% recurrence rate of HPV infection.

Recently attention has been focused on interferon injections.[8] Though preliminary results are encouraging the same was true for laser vaporization and cryotherapy in the original reports. Whether the initial optimistic results of interferon will be found to be ultimately correct still remains in doubt.

Other modalities of therapy such as 5FU cream have been equally futile.

HPV infection may have a long latency or, in fact, may be a lifetime infection. If this proves to be correct, the lack of the discovery of an efficacious treatment modality is understandable.

References

1. Howett, M.D. and Rapp, F: Basic Biology of Papillomavirus, Contemporary OB/GYN 28:110, 1986.
2. Erlich, K.S. and Normoyle, J.L.: Condylomata Acuminata: Waging Successful Fight Against Anogenital Warts, The Female Patient 12:51, 1987.
3. Meanwell, C.A.; Cox, M.F., et al: HPV 16 DNA in Normal and Malignant Cervical Epithelium: Implications for Aetiology and Behavior of Cervical Neoplasm, Lancet 1:703, 1987.
4. Benrubi, G; Holmes, K; Nuss, R.C., and Lammert, N: Efficacy of Cryotherapy for Treatment of Human Papilloma Virus Infection of Uterine Cervix, J. Florida M.A. 73:188, 1986.
5. Boothby, R; Benrubi, G., and Nuss, R.C.: Laser Treatment of Human Papilloma Virus Invection of Uterine Cervix, Colposcopy & Gyneologic Laser Surgery 2:25, 1986.
6. Ferenczy, A; Silverstein, S., et al: Importance of Latency in HPV Infections, Contemporary OB/GYN 30:71, 1987.
7. Riva, J.: Extended CO_2 Laser Vaporization of Subclinical Papilloma Virus Infection of Lower Genital Tract Presented at the 19th Annual Meeting, Society of Gynecologic Oncologists, Miami, Florida, February 1988.
8. Hatch, K.: Interferon Alpha-2 (Intron A) for HPV Vaginitis and Vulvitis Presented at the Ninth International Congress, International Society for the Study of Vulvar Disease, Broadbeach, Australia, September 1987.

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Systemic Lupus Erythematosus with Tibial Arteritis and Foot Gangrene

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ABSTRACT: ***Systemic lupus erythematosus is a multisystem disease with variable manifestations which have been the subject of multiple descriptions and studies. However, there is a paucity of information regarding its vascular complications and, in particular, the incidence of systemic arteritis in patients with this disease. We present the case of a 47-year-old Caucasian woman with known SLE in whom after 32 months arteritis of the lower extremities developed with cyanosis and gangrene of the first and second toes of the left foot.***

The results of angiographic studies, coupled with lack of evidence implying polyarteritis nodosa or atherosclerotic vascular disease as culprits, lead to the suggestion that gangrene of the lower extremity was due to arteritis presenting as a vascular complication of the underlying SLE.

Differentiating arteritis due to collagen vascular disease from atherosclerotic disease is important for correct utilization of therapeutic modalities in peripheral vascular obstruction.

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The association of peripheral vascular obstruction with collagen vascular disease such as polyarteritis nodosa and rheumatoid arthritis has been amply described.[1] However, with the exception of Raynaud's phenomenon, reports of peripheral vascular manifestations of systemic lupus erythematosus (SLE) have been scarce. There are some descriptions of arteritis in SLE. Several reports of coronary arteritis and myocardial infarctions in patients with SLE are noted.[2-4] The classic paper by Bonfiglio et al describes four cases. Three presented with angina and arteritis documented by coronary angiography,[5] and the fourth, a young girl with SLE, had myocardial infarction and coronary arteritis documented by postmortem pathologic findings. There are also case reports describing gastrointestinal arteritis in SLE.[6-8]

The pathologic changes of peripheral vascular involvement in SLE were described in 1951 by Lowman et al.[9] The initial report associating gangrene of the legs with involvement of medium size arteries in SLE was made by Keat and Shore[10] in 1958. Dubois et al[11] in 1962 described five cases of gangrene as a manifestation of SLE and emphasized treatment with large doses of corticosteroids for symptomatic relief and limitation of gangrene extension. A description of peripheral arterial occlusion in SLE was also made by Alarcon-Segovia and Osmondson[12] in 1984.

Case report ● A 45-year-old Caucasian woman presented with chief complaint in January 1985 of pleuritic chest pain, dry cough and generalized arthralgias of three months duration. She was apparently in good health until age 42 when she began experiencing joint pain in the hands, shoulders, knees, and morning stiffness which were treated with NSAI agents. She was admitted to a community hospital in November 1984 with pleurisy and

pericarditis, diagnosed as having SLE, and treated with prednisone with some improvement. There was no history of hypertension nor smoking. She denied previous trauma and was without cough, dyspnea, fever, nocturnal sweats, or lymphadenopathy. There was no weight loss, palpitations, dyspnea on exertion, paroxysmal nocturnal dyspnea or orthopnea. She also denied skin rash, mouth lesions, Raynaud's phenomenon, renal history, dysphagia, and proximal muscle weakness. Her father is a diabetic, and her mother died of cancer of the colon. The patient used prednisone 20 mg qd and furosemide 20 mg qd.

The physical examination revealed blood pressure 120/100 and pulse 84. The remainder of the examination was unremarkable except for cushingoid fascies and conjunctival hyperemia of the right eye. The lungs were clear, heart sounds normal, and pulses good throughout. Laboratory evaluations included normal CBC and urinalysis; BUN 11 mg/dl (normal 5-25). The ESR was 36 mm/hr (normal 0-20), C3 was 173 mg/dl (normal 124±26), and C4 was 23 mg/dl (normal 28.3±8.7); CH50 was 597 units/ml (normal 400-600). The rheumatoid factor was positive in a standard 1:20 dilution. The antinuclear antibody assay was positive in a homogenous pattern titer 1:1280, and specific antibodies to native DNA (nDNA) were also positive. Chest x-ray revealed left base atelectasis with pleurisy without any infiltrates or adenopathies. Electrocardiography revealed sinus tachycardia with nonspecific ST-T wave changes. The patient was diagnosed as having polyarthritis with serositis (pericarditis-pleuritis) secondary to SLE. She was treated with prednisone 20 mg/day, indomethacin 75 mg/day, colchicine 0.6 mg/day, and a potassium sparing thiazide diuretic once a day.

At follow-up the dry cough continued but disappeared after a few months treatment. The prednisone was tapered to 10 mg every other day. A papular rash develolped in the back. Her generalized arthralgias persisted over the following 19 months and she was given indomethacin daily. On physical examination the pertinent finding was basilar rales but partial remission of the cushingoid fascies, with reduction in her "buffalo hump" and "moon face" appearance. Further laboratory evaluation revealed hemoglobin 13.4 g/dl (normal 14±2), hematocrit 40% (normal 42±5), WBC 7100 cells/CC3 (normal 5000-10000) with a differential that included 48% lymphocytes (normal 25-35), segmented 46% (normal 54-62), mononuclear 4% (normal 3-7) and 2% eosinophils. Platelets were 509,000. BUN and creatinine remained normal. ESR was 78 mm/hr, C3 107 mg/dl, C4 21 mg/dl, ANA was positive in a homogenous pattern at 1:320 titers. The SLE went into remission during this period and prednisone was discontinued.

Weakness, fever and myalgias developed in September 1986 with exacerbation of her generalized arthralgias. Raynaud's phenomenon began in a finger of her right hand. ECG revealed no changes and a chest x-ray showed bibasilar atelectasis. She was treated only with nonsteroid anti-inflammatory agents.

Intercostal myositis developed in June 1987, also bilateral leg edema with erythromelalgia. The physical examination was unrevealing except for lower extremity varicosities. The edema of the legs was thought to be due to stasis. Laboratory evaluation revealed WBC 3700 and ESR 85 mm/hr; BUN, creatinine, urinalysis, serum protein, electrolytes and liver enzymes were all within normal limits. On August 12, 1987 an M-mode and two dimensional echocardiographic study revealed normal ventricular function; normal left atrium, right atrium, and left ventricular cavities, and absence of pathological pericardial effusion.

In September 1987 the patient presented with a two-week history of numbness, pain and cyanosis of the first and second toes of the left foot. Physical examination revealed cold and cyanotic toes and viable tissues of the foot. Pulses in the lower extremities were normal bilaterally and there was no leg edema. Doppler venous study revealed no evidence of deep vein thrombosis. The diagnosis was vasculitis of the first and second toes of the left foot and she was given prednisone 20 mg tid, nifedipine 20 mg tid, aspirin 30 mg qd, Percocet 1 tab qid.

She received two 500 mg intravenous boluses of cyclophosphamide on the 23rd and 25th of September. The patient became leukopenic. Laboratory evaluation revealed WBC 3600 cells/CC3, hemoglobin 12 g/dl, hematocrit 37%, negative testing for lupus anticoagulant and cryoglobulins. ANA was positive at 1:1280 titers; anti-DNA was also positive. The patient did not improve with treatment and the first toe of the left foot continued cyanotic and the second toe became necrotic (Fig.1).

She was admitted to Jackson Memorial Hospital on September 30. Physical examination revealed normal

Fig. 1.—The second left toe was gangrenous with a dry black scar. The great toe was ischemic with cyanosis and a bulla formation.

pulses in the lower extremities except for the dorsalis pedis which was normal on the right and nonpalpable on the left. Doppler study showed significant disease of the left proximal popliteal system. An aortic angiogram showed normal renal, hepatic, splenic and mesenteric arteries without microaneurysms. The abdominal aorta was normal (Fig. 2). Bilateral leg arteriograms revealed irregularities along the margins of the left and right anterior tibial arteries from their points of origin (Fig. 3). The arteriogram also demonstrated nonpatency of the middle and distal third of the left anterior tibial artery and nonopacification of the right posterior tibial artery (Fig. 4). The aortic angiogram-arteriogram revealed bilateral asymmetrical vascular disease consistent with arteritis of the lower extremities. A muscle biopsy showed no pathological abnormalities. The patient received a third bolus of cyclophosphamide on October 3 and was discharged that day. She was followed as an outpatient on prednisone treatment, aspirin, and nifedipine, and given another two boluses

Fig. 2.—Aortic angiogram with normal renal vascularization, normal hepatic, splenic and mesenteric arteries without microaneurysms.

of cyclophosphamide intravenously with increase in temperature of the foot. However, the tip of the second toe remained necrotic. The pain in the left foot subsided with treatment and during the next eight weeks the left first toe became pink with good perfusion and the second left toe developed an autoamputation of the gangrenous tissue.

In summary, this is a 47-year-old Caucasian woman with a history of SLE and pleuropericarditis since 1985, in whom after 32 months lupus arteritis of the lower extremities developed with cyanosis and gangrene of the first and second toes of the left foot without evidence of periarteritis nodosa or

Fig.3.—Bilateral leg runoff arteriogram. There is irregularity along the margins of the origin of the left and right anterior tibial arteries.

Fig. 4.—Bilateral leg runoff arteriogram. Only the proximal third of the left anterior tibial artery is patent. The right anterior tibial artery is patent. The left posterior tibial artery is complete. The right posterior tibial artery does not opacify.

atherosclerotic peripheral vascular disease.

Discussion ● The importance of atypical presentations of vascular manifestations of SLE has only been recognized in recent years. In one series the most common were: systemic hypertension (44%) followed by vasculitis (30%) and Raynaud's phenomenon (25%).[13] However, the incidence of diffuse systemic arteritis similar to polyarteritis nodosa was 2%.

It is important to differentiate between vasculitis of small arterioles and capillaries, common in SLE, and the rare occurrence of arteritis of the medium and large-size arteries.

In our patient the diagnosis of SLE was based on clinical manifestations which included arthritis, arthralgias, serositis and Raynaud's phenomenon.

Furthermore, laboratory analysis demonstrated elevated ESR, hypocomplementenemia and positive ANA and anti-DNA titers. These parameters led to the diagnosis of SLE following the criteria of the American Rheumatism Association.[14]

The vascular manifestation of digital gangrene of the left foot occurred 32 months after diagnosis and evaluation of her illness. However, many times these manifestations can precede by many years other clinical and laboratory findings of connective tissue disease making accurate diagnosis difficult.[15]

Our differential diagnosis for the gangrenous foot included atherosclerotic peripheral vascular disease, polyarteritis nodosa, and arteritis due to SLE.

Polyarteritis nodosa (PAN) may involve small as well as medium size arteries and can cause digital necrosis. Clinically, our patient had no evidence of peripheral neuropathy which may occur in 50-70% of cases of PAN.[16] There was also no evidence of abdominal pain, renal involvement, fever, arterial hypertension, eosinophilia, or positive HBSAG by laboratory evaluation. Furthermore, the aortic angiogram revealed no evidence of arteritis or microaneurysms of the renal, hepatic, splenic, or mesenteric arteries. This made PAN unlikely because there is evidence of involvement of renal and gastrointestinal arteries in a large percentage of cases. There was also no pathological evidence of polyarteritis on muscle biopsy.

Atherosclerotic vascular disease was also suspected. These infarcts could have resulted from cholesterol embolization from an atheromatous abdominal aortic aneurysm to a peripheral artery.[16] However, the patient was not in the older age group in which this disease is more prevalent. In addition, the symptomatology and laboratory abnormalities (compatible with SLE) accompanying the digital gangrene made this diagnosis unlikely. The aortogram revealed no aneurysmal dilatations of the abdominal aorta nor lesions in the ileofemoral arteries.

It is interesting that experimentally Minick et al[17] demonstrated a direct relationship between immunological injury to arteries and atherosclerosis. SLE being an autoimmune disease could cause the immunological injury to arteries by deposition of immune complexes and predispose to atherosclerosis of the middle and large-sized arteries, causing peripheral vascular obstruction.

In our patient, many factors point towards arteritis as the cause of the digital gangrene. She had active SLE at the time she presented with peripheral ischemia, and hypocomplementenemia developed which is compatible with arteritis in collagen vascular disease. In addition, the angiographic studies revealed bilateral asymmetric vascular disease supporting the diagnosis of arteritis of the lower extremities. There was also a good clinical response to therapy with cyclophosphamide and prednisone with an increase in temperature of the left foot and improved coloration of the first toe.

Histopathological confirmation of diagnosis by study of arterial specimen would have been ideal but not applicable in our patient.[18] Other complications of SLE associated with gangrene episodes such as circulating lupus anticoagulant and cryoglobulinemia were eliminated with appropriate investigations.

All the evidence presented in this case leads us to strongly suggest that arteritis secondary to SLE was the cause of peripheral ischemia and digital gangrene in our patient. We believe that in patients with SLE in whom peripheral ischemia or gangrene develops the diagnosis of lupus arteritis should be considered. This is extremely important because in lupus arteritis the clinical condition can be improved by proper utilization of high-dose steroids and immunosuppressive agents, and the patient's prognosis can be significantly altered.

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References

1. Bywaters, E.G.: Peripheral Vascular Obstruction in Rheumatoid Arthritis and Its Relationship to Other Vascular Lesions, Ann. Rheum. Dis. 16:84-103, 1957.
2. Heibel, R.H.; O'Toole, J.D.; Curtiss, E.I., et al: Coronary Arteritis in Systemic Lupus Erythematosus, Chest 69:700-703, 1976.
3. Przybojewski, J.Z.; Botha, D.; Klopper, J.F., et al: Systemic Lupus Myocardial Infarction, SAMJ 69:765-768, 1986.
4. Harrison, M.R.; Smith, M.D., et al: Postoperative Valve Ring Aneurysm Formation, Coronary Arteritis, and Myocardial Infarction in Systemic Lupus Erythematosus, Am. Heart J. 112: 414-418, 1986.
5. Bonfiglio, T.A.; Botti, R.E., et al: Coronary Arteritis, Occlusion and Myocardial Infarction Due to Lupus Erythematosus, Am. Heart J. 83:153-158, 1972.
6. Shapeero, L.G.; Myers, A., et al: Acute Reversible Lupus Vasculitis of Gastrointestinal Tract, Diag. Rad. 112:569-574, 1974
7. Phillips, J.C. and Howland, W.J.: Mesenteric Arteritis in Systemic Lupus Erythematosus, JAMA 206:1569-1570, 1968.
8. Helliwell, T.R.; Flook, D., et al: Arteritis and Venulitis in Systemic Lupus Erythematosus Resulting in Massive Lower Intestinal Haemorrhage, Histopathology 9:1103-1113, 1985
9. Lowman, E.W. and Slocumb, C.H.: Peripheral Vascular Lesions of Lupus Erythematosus, Ann Int. Med. 36:1206-1216, 1951.
10. Keat, E.C.B. and Shore, J.H.: Gangrene of Legs in Disseminated Lupus Erythematosus, Br. Med J. Jan. 4, 1954, pp.25-27.
11. Dubois, E.L. and Arterberry, J.D. Gangrene as Manifestation of Systemic Lupus Erythematosus, JAMA 181:366-374, 1962.
12. Alarcon-Segovia, D. and Osmondson, P.J.: Peripheral Vascular Syndromes Associated with Systemic Lupus Erythematosus, Ann. Int. Med. 61:907-919, 1965.
13. Ansari, A., Larson, P.H., and Bates, H.D. Vascular Manifestions of Systemic Lupus Erythematosus, J. Vasc. Disc. 37:423-432, 1986.
14. Tan, E.M., Cohen, A.S.; Fries, J.F., et al: The 1982 revised criteria for classification of systemic lupus erythematosus (SLE), Arthr Rheum 25:1271-1277, 1982.
15. DePalma, R.G.; Moskowitz, R.W., and Holden, W.D.: Peripheral Ischemia and Collagen Disease: Clinical Manifestations, Diagnosis, and Treatment, Arch, Surg. 105:313-318, 1972.
16. Kelley, W.N.: Textbook of Rheumatology. 1. Rheumatism 2. Collagen Disease I, W.B. Saunders Co. 1985, pp. 1141-1148.
17. Minick, C.R.; Alonso, D.R., and Rankin, L.: Role of Immunologic Arterial Injury in Atherogenesis, Thrombos Haemostas 39:302-311, 1978.
18. Gladstein, G.S., Rynes, R.I., et al: Gangrene of Foot Secondary to Systemic Lupus Erythematgosus with Large Vessel Vasculitis, J. Rheum. 6:540-553, 1979.

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Acute Appendicitis and Right Adnexal Torsion Occurring Simultaneously in Pregnancy

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***ABSTRACT:* A case is reported of acute appendicitis and torsion of the right adnexa simultaneously occurring in pregnancy. Prompt detection and avoidance of delay in the treatment of any surgical problem complicating a pregnancy are factors which most reliably assure maternal and fetal survival.**

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This work was done while the author was serving as staff surgeon at the Jacksonville Naval Hospital. The opinions and assertions expressed herein are solely his and should not be construed to reflect the views of the Department of the Navy or the Department of Defense.

Acute surgical problems arising during pregnancy pose a difficult diagnostic and therapeutic challenge. A pregnant female was recently encountered with an unusual combination of pathologic findings at laparotomy. This case demonstrates the benefit of an expeditious approach under such circumstances.

Case report ● A 24-year-old white female, gravida IV, para II, abortus I, was admitted to the obstetrics service of Jacksonville Naval Hospital with a four-hour history of severe, unrelenting pelvic and right lower quandrant abdominal pain of sudden onset. She was in the 22nd week of an uncomplicated intrauterine pregnancy. The pain radiated to the right groin and vagina and was associated with three episodes of vomiting and loose stools. She noted no history of fever, chills or dysuria, but did admit to a history of chronic intermittent right lower quadrant abdominal pain and vomiting for several years.

Physical examination revealed a temperature of 100.5°F, a generally soft abdomen with normal bowel sounds, and uterine fundus at the level of the umbilicus. There was localized tenderness in the right midabdomen without significant rebound tenderness. Pelvic examination showed the cervix to be closed and uneffaced, mild tenderness with cervical motion, and significant right adnexal tenderness without masses. A markedly tender, boggy 4 cm x 6 cm mass was palpated in the cul-de-sac. There was no blood in the stool. Fetal heart tones were normal.

Laboratory data showed a white blood cell count of 13,700/cu mm with a normal differential, hemoglobin of 11.3 gm%, normal serum electrolytes and amylase, and 20-25 WBC/hpf in the urine. Subsequent urine culture was negative. A pelvic sonogram confirmed a large complex mass in the cul-de-sac. No radiographic studies were done.

A laparotomy was performed nine hours after

admission through a low midline incision. The appendix appeared acutely inflamed without perforation and was removed. A clockwise torsion and infarction of the entire right adnexa was also found, with the adnexal structures lying in the cul-de-sac (Fig. 1). These structures were doubly ligated at their pedicle and excised. Pathology confirmed acute appendicitis and adnexal infarction as well as a 3 cm benign cystic teratoma of the right ovary.

Fig. 1.—Infarcted right adnexa at laparotomy. Gravid uterus is retracted to left. Note the twisted vascular pedicle.

The patient and fetus recovered uneventfully, being discharged on the third postoperative day. A healthy male infant was born four months later at term via spontaneous vaginal delivery.

Comments • Acute appendicitis is the most common extrauterine problem requiring laparotomy during pregnancy, having an average incidence of 1:1500 deliveries.[1] Although adnexal torsion has been reported during pregnancy,[2] there are no published figures of its overall incidence. On the premise that it occurs significantly less often than appendicitis in pregnancy, the probability of both pathologic entities simultaneously complicating a pregnancy must certainly be in the range of one in several million. To my knowledge, this represents the only reported case of such an occurrence in pregnancy.

McGowan's report of a large series of women with torsion of the uterine adnexa demonstrated that 23% of cases occur during pregnancy, 41% are associated with vomiting, two thirds occur on the right side, and all cases have abdominal pain and tenderness.[2] This series also demonstrated that all cases are associated with adnexal pathology, most commonly benign cystic teratoma. A past history of similar pain was found in almost one half of these cases and in no case was the pregnancy affected by the required surgical procedure. Thus, the patient reported herein presented a very typical clinical picture.

The most important principle to follow in evaluating the pregnant female for a surgical problem is that prompt diagnosis and treatment, with active cooperation between the general surgeon, obstetrician, and anesthesiologist, offer the greatest chance for maternal and fetal survival.[1,3] Babler first advanced this principle in 1908 with the assertion that "the mortality of appendicitis complicating pregnancy is the mortality of delay."[4] Although the anatomic and physiologic changes of pregnancy may complicate the clinical diagnosis of an intraabdominal process requiring surgical correction, the pregnancy itself should not contribute to any delay in the decision to operate. Early laparotomy is believed to be justified in the pregnant female if there is a reasonable suspicion of acute appendicitis.[5] A negative exploration and incidental appendectomy has been shown in recent years to carry a minimal maternal and fetal mortality,[1,3,5,6] Delaying necessary surgery until the onset of peritonitis and sepsis, however, is associated with a 50% to 100% chance of perinatal mortality.[3] Thus, a high index of suspicion and a willingness to operate whenever the potential for a surgical problem exists are the factors that best ensure the welfare of mother and child.

References

1. Babaknia, A.; Parsa, H., and Woodruff, J. D.: Appendicitis During Pregnancy, Obstet. Gynecol. 50:40-44, 1977
2. McGowan, L. Torsion of Uterine Adnexa, Am. J. Surg. 108:811-814, 1964
3. Weingold, A. B.: Appendicitis in Pregnancy, Clin. Obstet. Gynecol. 26:801-809, 1983.
4. Babler, E. A.: Perforative Appendicitis Complicating Pregnancy, JAMA 51:1310-1313, 1908
5. Masters, K.; Levine, B. A.; Gaskill, H. V., and Sirinek, K. R.: Diagnosing Appendicitis During Pregnancy, Am. J. Surg. 148:768-771, 1984
6. Cunningham, F. G. and McCubbin, H. J.: Appendicitis Complicating Pregnancy, Obstet. Gynecol. 45:415-420, 1975.

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Classification of Depression as a Guide to Pharmacotherapy

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ABSTRACT: With publication of the latest revision of the third edition of the Diagnostic and Statistical Manual of Mental Disorders *(DSM3-R), research diagnostic criteria have been established for the entire spectrum of mental disorders. Various types of depression are classified and placed into multiple categories of mental illness. This has presented a complex and confusing situation to all clinicians treating depressed patients.*

Of all depressive disorders, the most significant morbidity and mortality is seen in those classified as major depressions. This article presents a rational approach to the diagnostic categorization of major depression which is discussed with regard to its usefulness in deciding which pharmacologic treatment is most efficacious for each particular form.

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The treatment of depression requires a multifaceted approach to the patient. A decision must be reached regarding use of psychotherapy and pharmacotherapy alone or in combination. This requires an indepth knowledge of the patient including his/ her history of present and past illnesses, developmental, social, family, and sociocultural histories, and mental status and physical examinations. Once this data base has been obtained, the clinician must have a working knowledge of psychopathology to determine which treatments would be most beneficial.

In patients with a major depression, psychotherapy is efficacious.[1] With pharmacotherapy they appear to have a synergistic effect such that the combination is better than either treatment alone.[2] Furthermore, hypothesized contraindications to the use of pharmacotherapy and psychotherapy in combination have thus far proven to be unfounded.[3]

This paper focuses on those patients whose symptoms are severe enough to classify them as suffering from a major depression. It describes a method of formulating a rational approach to selecting a medication once the decision to use some form of pharmacotherapy has been reached.

The introduction of DSM3 laid the foundation for a better understanding of affective disorders. The use of specific diagnostic criteria made possible the scientific evaluation of their response to various forms of treatment. These criteria continue to be retained in its latest revision, DSM-3. The terminology presented in DSM3-R requires the clinician to be familiar with a large number of symptoms and specific criteria. This appears formidable even to the professionals for whom psychiatry is the primary specialty. However, after understanding a few basic facts, the new system is not only easy to comprehend but if used properly can form the basis for rational pharmacotherapy.

Diagnostic features ● The first task in diagnosis of

the depressive disorder should be to determine if it is a major depression. DSM3-R lists approximately eight ways to categorize a "major depression" (Table 1). An additional 11 terms are used to describe "other" depressions (Table 2). This article deals only with major depressions. The term "major depression" has strict inclusive and exclusive criteria to be met in order to establish the diagnosis.

Table 1.—Categorization of Major Depression.

1. **Unipolar Major Depression**
   a. With psychotic features
   b. Without psychotic features
   c. With melancholia
   d. Without melancholia
2. **Depressed Bipolar Disorder**
   a. With psychotic features
   b. Without psychotic features
   c. With melancholia
   d. Without melancholia

Table 2.—Other Depressions.

Dementia with depression
Psychoactive substance induced mood disorder
Organic mood disorder — depressed
Schizoaffective disorder
Mixed bipolar disorder
Cyclothymia
Dysthymia
Bipolar disorder not otherwise specified
Depressive disorder not otherwise specified
Adjustment disorder with depressed mood
Uncomplicated bereavement

The conditions to be excluded are very important as they reflect the absence of paranoid disorder, schizophrenia, medical illness (Table 3), or reaction to drug or toxic substances (Table 4) whose first presenting symptoms may be depression. What they tell us is that depressive symptoms characteristic of a major depression may also be secondary to other psychiatric or medical illnesses.

In consulting DSM3-R it becomes clear that the criteria to make the diagnosis of major depression can be divided into several key areas (Table 5): dysphoric mood; psychological symptoms; vegetative symptoms. Once other conditions have been ruled out, depressive symptomatology must be further categorized. This is necessary because in a major depression the spectrum of the patient's presenting illness will determine the most efficacious form of treatment (Table 6).

First is the distinction between unipolar and bipolar types of recurrent affective disorders. In unipolar cases a tricyclic antidepressant (TCA) alone is the first choice of treatment during the acute episode.[4] Lithium may be added for a short period of

Table 3.—Medical Illnesses Which Can Present With Depression.

1. **Infectious**
   a. Viral agents
      Influenza
      Viral hepatitis
      Viral encephalitis
      Mononucleosis
      AIDS
   b. Bacterial agents
      Brucellosis
      Toxoplasmosis
      Syphilis
   c. Fungal agents
      Candida albicans
2. **Neurologic**
   a. Slow growing cerebral tumors
      Meningioma
      Condroma
   b. Basal ganglia disease
      Parkinson's disease
      Huntington's chorea
   c. Multiple sclerosis
   d. Epilepsy
3. **Sleep disorders**
   a. Narcolepsy
   b. Klein-Levine-Critchley syndrome
4. **Endocrine**
   a. Cushing's syndrome
   b. Addison's disease
   c. Diabetes mellitus
   d. Pancreatic disease
   e. Hypo- and hyperthyroidism
   f. Hypoparathyroidism
5. **Gastrointestinal**
   a. Crohn's disease
   b. Ulcerative colitis
   c. Peptic ulcer disease
   d. Irritable bowel syndrome
6. **Immunologic**
   a. Systemic lupus erythematosus
   b. Rheumatoid arthritis
   c. Temporal arteritis
   d. Sjogren's syndrome
7. **Metabolic**
   a. Acute intermittent porphyria
   b. Vitamin deficiencies
      Folate
      B12
      Scurvy
      Pellagra
   c. Hypervitaminosis A

time if the patient does not respond to the TCA. Lithium has recently been found to augment the antidepressant effect of TCAs in patients having no improvement of depressive symptoms after six weeks of treatment with TCAs.[5,6]

In bipolar disorders where the patient has recurrent episodes of both depression and mania, a depressive episode may be treated with either a TCA or a monoamine oxidase inhibitor (MAOI).

Lithium should be prescribed along with the antidepressant to avoid the danger of triggering a manic episode (switching phenomenon).[7] Serendipitously, lithium alone appears to have an antidepressant effect that has been reported to improve major depression in up to 30% of patients.

Depression not otherwise specified is a catch-all category. It was designed by the authors of DSM3-R to also include those patients who may have all the characteristics of a major depression but possess other symptoms which are atypical from the majority of cases. With regard to treatment, two subtypes have been identified which may respond better to MAOIs than TCAs: those with atypical vegetative symptoms such as increased sleep and appetite; and those with prominent anxiety of hysterical features.[8]

Another important diagnostic feature relating to

Table 4.—Drugs and Toxins Which May Cause Depression.

1. **Analgesics and nonsteroidal antiinflammatory agents**
   Ibuprofen
   Indomethacin
   Baclofen
   Opiates — methadone withdrawal
   Pentazocine
   Phenacetin
   Phenylbutazone
2. **Anticonvulsants**
   Carbamazepine
   Phenytoin
3. **Antihistamines**
   Cyproheptadine
4. **Antihypertensives**
   Clonidine
   Quanethidine
   Hydralazine
   Methyldopa
   Propranolol and other B-blockers-timolol
   Reserpine
5. **Antimicrobials**
   Ampicillin
   Chloramphenicol
   Antimalarials — chloroquine, hydroxychloroquine, amodiaquine, primaquine
   Clotrimazole
   Cycloserine
   Dapsone
   Ethionamide
   Griseofulvin
   Isoniazid
   Metronidazole
   Nalidixic acid
   Nitrofurantoin
   Procaine penicillin
   Streptomycin
   Sulfonamides
   Trimethoprim sulfa
   Tetracycline
6. **Antimigraine drugs**
   Methysergide
   Pizotifen
7. **Antineoplastic and immunosupressive**
   Azathioprine
   L-asparaginase
   Bleomycin
   Mithramycin
   5-fluorouracil
   Tamoxifen
8. **Antiparkinsonian drugs**
   Amantadine
   L-dopa
   Bromocriptine
   Carbidopa
9. **Antipsychotic drugs**
   Phenothiazines
   Fluphenazine, enanthate/decanoate
   Prochlorperazine
   Haloperidol
10. **Cardiac drugs**
    Digitalis
    Lidocaine
    Procainamide
11. **Sedatives and anti-anxiety drugs**
    Barbiturates
    Benzodiazepines
    Chloral hydrate
    Ethanol
    Other sedative/hypnotics
    Propranediols (meprobamate)
12. **Hormones**
    ACTH
    Corticosteroids
    Oral contraceptives
    Estrogen
13. **Stimulants and anorexic drugs**
    Amphetamine
    Diethylpropion
    Fenfluramine
    Phenmetrazine
    Pemoline
    Diethylpropion hydrochloride
    Methylphenidate
14. **Miscellaneous**
    Ethanol
    Diphenoxylate
    Disulfiram
    Caffeine
    Cimetidine
    Halothane
    LSD
    Metrizamide
    Phenylephrine
    Tryptophan
    Monosodium glutamate
    Mercury
    Thallium

treatment is whether the depression is delusional or nondelusional. Delusions accompanying a major depression are usually mood congruent as opposed to delusions seen in schizophrenia which are usually bizarre or mood incongruent. If the patient manifests delusions and/or hallucinations he will tend to respond better to electroconvulsive therapy (ECT) or a combination of an antidepressant and a neuroleptic rather than an antidepressant drug alone.

An additional influence on treatment is the presence or absence of melancholia. Melancholia as described in Table 7 reflects a severe degree of depression predicting a good response to ECT[9-11] and other somatic therapies.

Preventive therapy ● Once symptomatic relief of depression is achieved, the question of who should be placed on preventive therapy arises. In patients who present to university teaching hospitals with a major depression, 50 to 80% will have at least one recurrence in their lifetime. Ten to 15% of patients with unipolar depressive symptoms will have an episode with manic or hypomanic symptoms in their life. Further complicating the treatment situation is the fact that 15 to 20% of patients with recurrent unipolar affective disorder do not recover fully from any given episode and have persistent symptoms for at least two years.[12]

Various factors can increase the risk of recurrence such as alcoholism, other drug dependence, an additional psychiatric disorder, family history of depression, or older age at onset. In individuals recovering from a major depression, the persistance of mild depressive symptoms increases the potential for recurrence. As the number of episodes of depression increase, the probability of developing an additional depressive episode also increases.[12] Patients with any of these risk factors should be considered candidates for preventive therapy. Other factors to be considered are a past history of suicide attempts, past psychotic episodes, and functional or social impairment.

Table 5.—Symptoms of a Major Depression.

Dysphoric mood must be prominent (though not necessarily predominant), persistent, and is usually seen in conjunction with symptoms in the categories listed below.

Psychologic	Vegetative
Anhedonia	Psychomotor retardation or agitation
Loss of interest or pleasure	Loss of energy or fatigue
Hopelessness	Decreased ability to think or to concentrate
Worthlessness	Slowed thinking and indecisiveness
Inappropriate guilt	Weight increase or decrease
Self-reproach	Appetite increase or decrease
Recurrent thoughts of death	Insomnia or hypersomnia
Suicidal ideation or attempts	Decreased libido

Table 6.—Treatment of a Major Depression, Organic Etiologies and Schizophrenia Ruled Out.

	Acute Rx	If Refractory	Prophylaxis	Breakthrough of Depressive Symptoms
1. Typical				
a. Unipolar Major Depression	TCA	Add LiCO3 or consider a different TCA, an MAOI or ECT	TCA or whatever was used to control the acute episode	Check thyroid function tests then increase dose of TCA. If no response then consider changing to a different TCA, an MAOI or ECT
If psychotic features	Add neuroleptic or consider ECT	Consider adding LiCO3, Tegretol or a course of ECT	TCA	Add neuroleptic and check thyroid function tests
b. Bipolar Depressed	TCA plus LiCO3	Change to an MAOI, or consider ECT	LiCO3 or TCA	Check thyroid function tests and lithium level then increase TCA or lithium
If psychotic features	Add neuroleptic or consider ECT	ECT or consider adding Tegretol	LiCO3	Check lithium level and thyroid function tests then add neuroleptic

In choosing a medication for preventive therapy, it is best to continue the drug to which the patient responded during the acute episode. Lithium and TCAs have been found to be relatively equivalent in their ability to prevent recurrences. Hence, the choice is determined by the side effect profile of the medication. In the elderly or patients with renal disease causing decreased lithium clearance, a TCA should be used. TCAs, however, have the potential to cause urinary retention, cardiac arrhythmias, and increased intraocular pressure. Lithium is the drug of choice in patients who have a first degree relative with bipolar affective disorder.

The risks of maintaining a patient on preventive therapy are essentially the same as the short-term adverse effects of antidepressant medication. Lithium, however, appears to present an increased risk of hypothyroidism the longer a patient is maintained on it. Similarly, a majority of patients treated with long-term lithium therapy appear to have impaired renal tubular function. This causes a decrease in urine concentrating capacity which may not be entirely reversible once lithium is discontinued. A once daily dosage schedule with lithium given before bedtime may be less nephrotoxic than the standard divided-dose schedule.[13] TCAs present a minimal risk of arrhythmias except for those individuals with cardiac disease. Both lithium and TCAs have teratogenic effects when administered in the first trimester of pregnancy. Among other side effects, TCAs lead to weight gain, orthostatic hypotension, confusional states, and exacerbations of mania. Other side effects described with lithium have been polydipsia, polyuria, weight gain, hair loss, fatigue, and dulling of the senses.[14]

Table 7.—Melancholia.

To establish the presence of melancholia, the patient must display anhedonia and at least three of the following:

1. Depression worse in morning
2. Early morning awakening
3. Psychomotor retardation or agitation (marked)
4. Anorexia or weight loss
5. No significant personality disturbance prior to the first major depressive episode
6. History of previous major depressive episodes followed by complete or nearly complete recovery
7. Previous good response to psychopharmacologic therapy or ECT

The length of time a patient is maintained on preventive therapy should be determined on an individual basis. Up to 50% of patients with unipolar depressive disorders relapse within two years.[12] The likelihood of recurrence is greatest within the first four to six months and slowly decreases over the next two years.[12] Hence, patients considered to be candidates for preventive therapy should be kept on their medication for at least six months after resolution of the acute episode. In many cases, the medication may have to be used for an extended period of time, and in some cases even for life.

No guidelines have been established for discontinuation of preventive pharmacotherapy. The medication should be tapered gradually. TCAs should be discontinued over a period of weeks to months with larger decreases in dose taking place initially and smaller

decreases taking place once the total daily dose is 50 mg or less. Discontinuation of lithium pharmacotherapy should also be spread over several weeks.

During the course of preventive therapy breakthrough episodes of depression may sometimes occur. In these instances, it is best to delay purely symptomatic treatment with anxiolytics or sedative/hypnotics in order to determine if a recurrent episode has actually begun. If the patient is on lithium, a serum lithium level should be obtained to assure compliance and determine if an increase in dose is warranted. Also, thyroid function tests should be obtained as hypothyroidism can mimic symptoms of depression. If the patient is on a TCA, a serum blood level should be obtained.[15] Usually all that is required is a small increase in dosage. If the patient is in the therapeutic range and does not respond, the replacement of the TCA with a different TCA or an MAOI should be considered.

In using any antidepressant what is most critical is the administration of a dose high enough to achieve an adequate antidepressant effect. Recent studies have concluded that between 30 to 80% of so-called "refractory" patients receive inadequate doses of TCA. And, when adequate doses are later instituted, 50% of these patients improve. To put it simply, mild depressions should not be treated with minimal doses of antidepressants. A depression severe enough to be treated requires a dose high enough to reach a therapeutic level. And, when a patient fulfills the diagnostic criteria for depression, he should receive an adequate quantity of antidepressant medication without delay. Quitkin,[16] in reviewing the available dose response studies, concluded that "patients should receive 300 mg. of imipramine or equivalent, and a separate trial of 90 mg. of phenelzine or equivalent, before concluding they are treatment refractory."

Along with the use of serum drug levels, other recommended laboratory studies include urinalysis, creatinine, BUN, ECG, and thyroid function tests prior to initiating lithium therapy. Lithium levels should be checked approximately five days after increasing lithium doses and at one to three month intervals at steady state doses. Thyroid function tests and serum lithium concentration should be checked every six to 12 months during preventive therapy.

At times there will be cases that do not fit easily into the outlined schema for major depression. On such occasions psychiatric consultation is often advisable. Other reasons for seeking psychiatric consultation include: concomitant psychosis, homicidal or suicidal ideation, failure of a patient to respond to antidepressant therapy, and when ECT is the treatment of choice.

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References

1. Weissman, M.M.: Psychological Treatment of Depression, Psychotherapy Research: Where Are We and Where Should We Go? Williams, J.B., Spitzer, R.L. (eds), New York, Guilford Press, 1984.
2. Group for the Advancement of Psychiatry: Pharmacotherapy and Psychotherapy: Paradoxes, Problems and Progress, New York, Mental Health Materials, Inc., 1975.
3. Rounsaville, B.J.; Klerman, G.L., and Weissman, M.M.: Do Psychotherapy and Pharmacotherapy for Depression Conflict? Arch. Gen. Psychiat. 38:24-29, 1981.
4. Georgotas, A.: Affective Disorders: In Pharmacotherapy, Comprehensive Textbook of Psychiatry IV. Kaplan, H.I., Sadock, B.J. (eds), Baltimore, William & Wilkins, 1985.
5. DeMontigny, C.; Grunbert, F.; Mayer, A., et al: Lithium Induces Rapid Relief of Depression in Tricyclic Antidepressant Nonresponders, Br. J., Psychiat. 138: 252-256, 1981.
6. DeMontigny, C.; Cournoyer, G.; Morissette, R., et al: Lithium Carbonate in Tricyclic Antidepressant-Resistant Unipolar Depression, Arch. Gen. Psychiat. 40: 1327-1334, 1984.
7. Bunney, W.E. Jr.: Psychopharmacology of Switch Process in Affective Illness, Lipton, M.A., DiMascio, A., Killan, K.F. (eds), Psychopharmacology: Generation in Progress, New York, Raven Press, 1978.
8. Quitkin, F.; Rifkin, A.; and Klein, D.F.: Monoamine Oxidase Inhibiters, Review of Antidepressant Effectiveness, Arch. Gen. Psychiat. 36:749-760, 1979.
9. Fink, M.: Convulsive Therapy: Theory and Practice, New York, Raven Press, 1979.
10. Kendall, R.E.: Present Status of Electroconvulsive therapy, Br. J. Psychiat 139: 265-283, 1981.
11. Electroconvulsive Therapy: Consensus Development Conference Statement, Washington, D.C., National Institute of Mental Health, U.S. Government Printing Office, 1985.
12. Mood Disorders: Pharmacologic Prevention of Recurrences, Consensus Development Panel, Am. J. Psychiat. 142:469-475, 1985.
13. Hetmar, O.: Clemmessen, L.; Ladefogel, J., and Rafaelsen, O.J.: Lithium: Long-term Effects on Kidneys, III. Prospective Study, Acta. Psychiatr. Scand. 75:251-258, 1987.
14. Schvehla, T.J.; Faust, L.; Herjanic, M.; and Muniz, C.E.: Lithium in Affective Disorders, Am. Fam. Physician 36:169-175, 1987.
15. Glassman, A.H.; Schildkraut, J.J.; Orsulak, P.J., et al: Tricyclic Antidepressants — Blood Level Measurements and Clinical Outcome: APA Task Force Report, Am. J. Psychiat. 142-142, 155-162, 1985.
16. Quitkin, F.M.: Importance of Dosage in Prescribing Antidepressants, Br. J. Psychiat. 147:593-597, 1985.

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The Florida Teratogen Information Service

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***ABSTRACT:* There is widespread need for current, accurate information about the effects of drugs and occupational and environmental exposures on the fetus, particularly among obstetricians and pediatricians. Patients are requesting the information as part of routine health care. A Teratogen Information Service has evolved at the University of Florida College of Medicine to disseminate this information throughout the professional health-care community.**

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The University of Florida, in conjunction with Children's Medical Services, Department of Health and Rehabilitative Services, has developed a Teratogen Information Service (TIS) to serve the professional community of Florida. It provides, without charge, accurate and current information about the effects of drugs, and occupational and environmental exposures on pregnancy outcome. The TIS has assembled information relevant to maternal or paternal exposures that occur prior to or during pregnancy. Such exposures include drugs (prescription, over-the-counter and recreational), radiation, infections, chemicals and environmental conditions such as exercise and hyperthermia. The TIS staff consists primarily of a coordinator and a director. The director is a physician with a specialty area in clinical genetics.

Patient concerns about potential teratogens often demand cautious or qualified answers from the physician. The cases presented illustrate situations where such questions often arise. In this review we explain how a teratogen information service provides timely data and thereby helps the practitioner answer difficult questions about potential teratogens.

Assessment of cases • Case Study: A laboratory technician of 11 weeks gestation submits a list of chemicals that she is exposed to by inhalation or by direct skin contact during her daily work. The list includes inorganic mercury, benzyl peroxide, titanium dioxide, carbon disulfide, diethyl ether, toluence, butanol and acetic anhydride. She asks how these agents can affect her baby.

Case Study: A 31-year-old woman was involved in a car accident and sustained chest and abdominal injuries. Her hospital treatment involved general anesthesia using nitrous oxide and enflurane and drug therapy with erythromycin, ampicillin, promethazine, lidocaine, morphine and meperidine. She also had

several diagnostic x-ray studies. Two weeks after the accident it was determined that she was pregnant and that her estimated date of conception was five weeks prior to the accident. Her question is what effect, if any, these exposures will have on her baby.

Assessment of the first case study can be a timely process requiring consultation of all the TIS references. Investigation into the second case study uses more standard TIS resources. An abbreviated example of a reply to this case would include the following information: Nitrous oxide and enflurane are general anesthetics administered by inhalation. There has been no increase in the incidence of congenital abnormalities in the offspring of women exposed to these agents during pregnancy. Meperidine, promethazine, idocaine, penicillin and erythromycin exposure during pregnancy has not been associated with an increased rate of malformations.

In x-ray studies or treatments, the rad exposure can be determined and the fetal effects can be estimated accordingly. It is believed the incidence of congenital malformations are not increased by total doses less than or equal to 5 rads during first trimester of pregnancy.

Obstetricians, family practitioners, nurse clinicians and genetic counselors are seeing cases similar to these more frequently than ever before. This increase is understandable considering the greater public awareness about potential teratogens and the fact that almost 50% of pregnant women are exposed to at least one medication during pregnancy.[1] Other studies suggest that the average pregnant patient may be exposed to as many as six drugs during pregnancy.[2]

The goal of the TIS is to reduce birth defects caused by unnecessary teratogen exposures. This goal is accomplished primarily through dissemination of information to health care practitioners.

Looking for answers ● When faced with questions about the possible adverse effects of medication or environmental exposures on fetal development, where does the practitioner look for answers? A 1982 study determined that the Physician's Desk Reference (PDR) was the most frequently used source of pregnancy information with medical journals second and continuing education meetings third.[3] This study emphasized the need for a comprehensive, centralized source of information. Such a source might enhance practitioners' knowledge about potential teratogens and thus improve prenatal care and counseling. Preventive health initiatives resulting in avoidance of potential teratogen exposures would also improve fetal outcome.

Practitioners may use the TIS by calling the coordinator. When a caller contacts the TIS, basic information is requested regarding the agent and pregnancy history including amount, timing and duration of exposure and age, gravida, parity and LMP of the woman involved. Identification of date, dose, and duration of exposure is critical since the greatest risk exists during embryonic organogenesis occurring in the first 12 weeks of gestation.

Table 1.—Types and Frequencies of Requests.

Requests	Frequency Percent
Medication	64
Occupational/Environmental	21
Radiation	6
Maternal factors	6
Paternal exposures	3

Table 2.—Thirty Most Frequently Requested Agents.

Cocaine	Meperidine	Prednisone
Marijuana	Erythromycin	Phenytoin
Progestins	Alprazolam	Metronidazole
X-rays	Acyclovir	Methamphetamine
Propranolol	Tylenol/Codeine	Isoflurane
Promethazine	Sodium Thiopental	Ibuprofen
LSD	Agent Orange	Cyclobenzaprine
Alcohol	Methyl Ethyl Ketone	Radiation Therapy
Darvacette	Toluene	Duras Ban (pesticide)
Nitrous Oxide	Rubella Vaccine	Acetic Acid

Once this information is obtained, expedient research on the agent begins. The TIS has several different types of resources available. Several on-line computer data bases are consulted for the most current, teratogen-specific information. The two most frequently used are REPROTOX and TERIS. REPROTOX provides current assessments about potentially harmful effects of selected drugs, chemicals and physical agents on humans. TERIS primarily provides information on the teratogenic effects of the most commonly prescribed medications. Several textbooks also serve as reference material. A list of the most commonly used texts is available upon request. In addition, consultations from the genetics, obstetrics, pharmacy and radiology staff at the University of Florida supplement this information search.

After data about specific exposures have been compiled, an agent summary of all the information is sent to the primary health care practitioner within seven to ten days. Each summary is in letter form with relevant bibliographies attached. When appropriate, reprint articles or selected annotations are included. Evaluation forms for the health care provider and for the patient are included. These evaluations are very short and help the TIS evaluate the quality of the information provided.

The TIS provides accurate and current general agent or exposure information to referring health care practitioners within a reasonable period of time and

expressly does not recommended specific counseling or treatment strategies. Patient management and decision making rests solely with the practitioner accessing the TIS. Information provided by the TIS must be interpreted by the practitioner due to the many confounding factors in the mother and fetus that may affect fetal outcome.

Since starting operation in February 1987, the TIS has identified several categories of callers. Health professionals seeking information about patients who are either pregnant, planning a pregnancy or were previously pregnant comprise the majority of callers. Women or their male partners in these three catagories represent a small percentage of total callers. Generic information about an agents' teratogenicity will be given to public callers if, in the judgment of the TIS coordinator, such information is provided in the spirit of community education and is not related to a specific pregnancy. It is clear from the various types of callers that women in all phases of reproductive planning are in need of information from the TIS.

Table 1 summarizes the general types and frequencies of agents requested. Although medications comprise the majority of requests (64%), almost one fourth of all requests involve environmental or occupational exposures. These latter exposures require more research time for the TIS staff since they often involve assessment of multiple chemical agents that are not represented on established on line teratogen data bases. Human or animal data are often extremely limited for such exposures.

The TIS has also identified the most frequently requested agents since beginning the service. Table 2 lists the 30 most commonly requested agents from February 1987 to September 1987.

The Florida legislature has provided funds to establish TIS programs at the University of Miami and the University of South Florida. As the program evolves, Florida will have one of the nation's most comprehensive, integrated and accessible teratogen information systems. Practitioners may call the TIS coordinators at the following numbers:

University of Florida — (904) 392-4104
University of Miami — (305) 547-6549
University of South Florida — (813) 974-2262

References

1. Bracken, M.B. and Holford, T.R.: Exposure to Prescribed Drugs in Pregnancy and Association with Congenital Anomalies, Obstet. Gynecol, 58:336-343, 1981.
2. Doering, P.L. and Stewart, R.B.: Extent and Character of Drug Consumption During Pregnancy JAMA 239:843, 1978.
3. Hatton, R.C.; Doering, P.L., and Frias, J.L.: Physicians' Sources of Information About Teratogenic Effects of Drugs, Drug Information Journal 6:148-154, 1982.

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Editor — **Jacques R. Caldwell, M.D.**

Medicare Fiscal Policy: In Critical Condition

Introduction ● Diminishing provider payments have jeopardized our nation's system of health care for senior citizens. The mission of the 1965 Medicare law was to guarantee health care coverage for the elderly and disabled, while promising adequate reimbursement to its providers. That promise has been broken through several consecutive annual cuts in Medicare funding, causing a financial crisis in hospitals today. The implications of this policy are discussed, with suggestions for physicians in taking an active political role in joining hospitals to lobby Congress to protect Medicare in 1989 and beyond.

Medicare is in critical condition, and a review of the program's evolution helps put its current problems into sharp focus.

The Medicare program was signed into law in 1965 to guarantee health care coverage for the nation's elderly and disabled. It was designed to assure that its beneficiaries would receive the same accessibility and quality of care as those who could afford to pay for service. In heralding the new law, President Lyndon B. Johnson observed: "No longer will illness destroy savings so carefully put away...no longer will older Americans be denied the healing miracle of modern medicine."[1]

The promise ● The system also made a promise to health care providers: that there would be adequate reimbursement for the services they provided to its beneficiaries. Federal legislation mandated that participating hospitals were to accept Medicare assignment as payment in full for Part A services rendered to all Medicare enrollees, regardless of their personal income level. In return, these services were to be reimbursed on the basis of cost, including reimbursement for operating expenses, capital expenses, and teaching programs. It is generally accepted that the United States has since developed the highest quality system in the world for delivering health care to its senior citizens.[2]

The premise of DRGs ● In 1983 the federal government devised a new reimbursement system to create an incentive for hospitals to reduce costs. It introduced the Diagnosis Related Group (DRG) method of classification to standardize fixed payments according to specific diagnoses, promising a built-in inflation factor to keep payments up with yearly Consumer Price Index increases. The premise of this proposal appeared to be sound, in view of the government's promise to adjust these fixed payments by the annual inflation factor.[3]

This so-called Prospective Payment System (PPS) was to be updated each year by evaluating the standardized payment amount per diagnosis, and by recalculating the DRG weights that are applied to each diagnosis. Congress and the Health Care Financing Administration (HCFA) were to evaluate the hospital market basket (inflation) index to determine the actual cost increase to hospitals for its services (utility rates, insurance premiums, wages, etc.) and adjust accordingly each year.

However, once the DRG changes were in place, the promise began to change. The inflation factor became subject to review each year by congressional committees and yearly increases never fully materialized. The original promise of Medicare and the subsequent PPS system to provide fair reimbursement has not been kept, jeopardizing the quality and effectiveness of the entire system. It has been estimated that in 1988, over 40% of all hospitals will have a net operating loss for providing service to their Medicare patients.[4]

Growing payment gap ● The subsequent result has been that while the cost of living has risen, Medicare payments to providers have not kept up. The gap between actual Medicare costs and actual Medicare payments increases each year. Currently, inflation in the cost of goods and services that hospitals buy is approximately 5% per year, but the actual annual

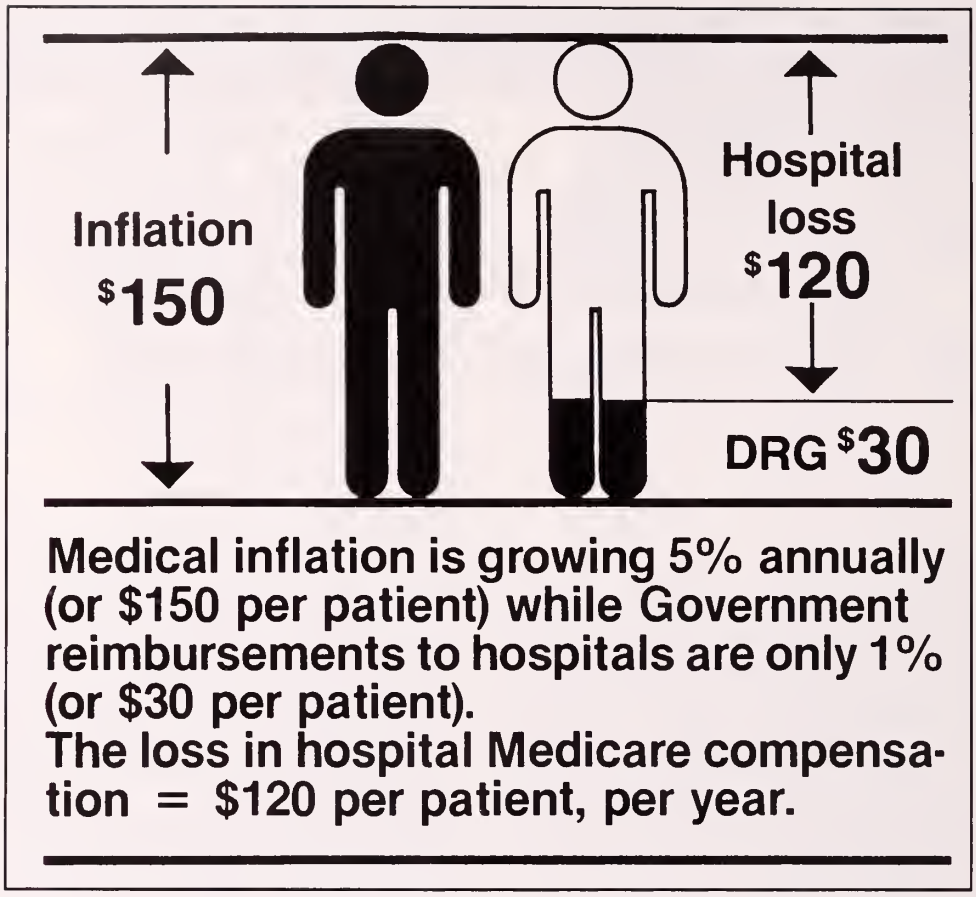


Figure 1.

increase in Medicare payments during the last five years has grown by only 1%. As a result, for the past several years, Medicare increases have fallen behind cost increases by more than 50%. (Fig. 1).[5]

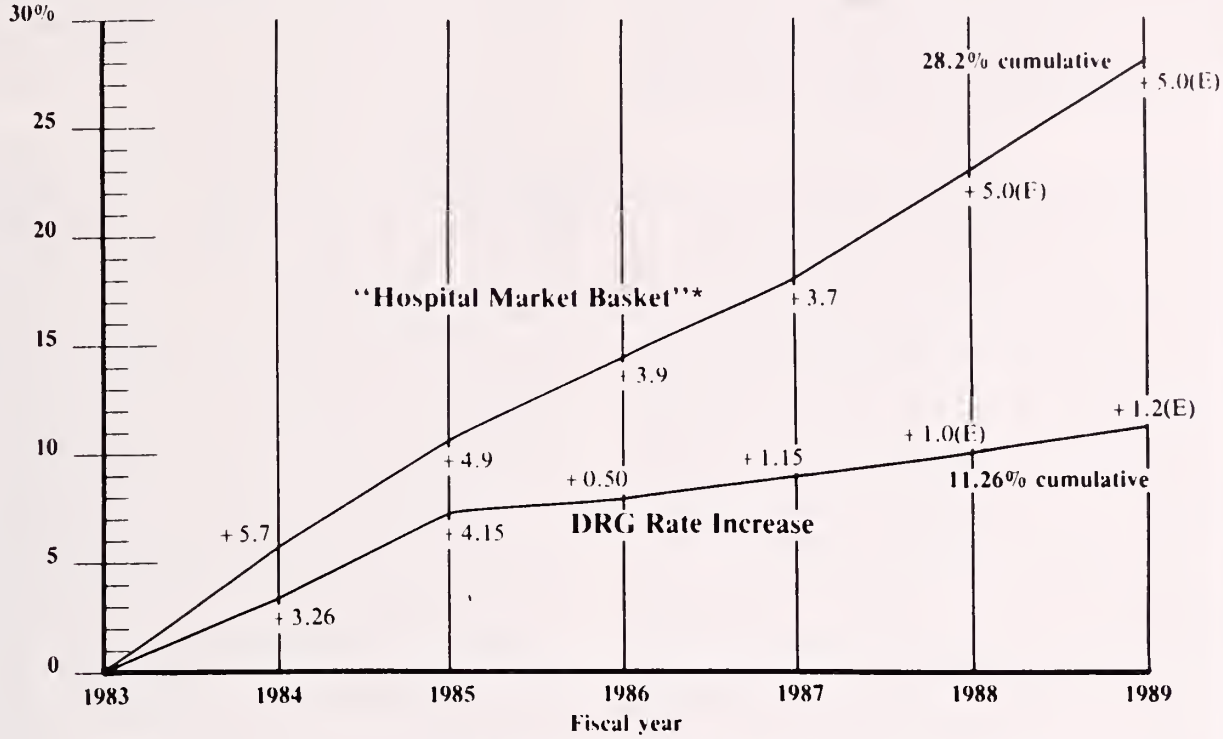
Impact on community hospitals ● The impact on these funding shortfalls at Humana Hospital-Daytona Beach, for example, is a microcosm of the community hospital experience throughout our society. This hospital is a 214-bed acute care facility. Medicare payments currently account for 45% of total hospital revenues. Because of the importance of this revenue and cost center, hospital management undertook a comprehensive program to reduce operating costs where feasible, and to secure the cooperation and help of its medical staff in reducing inpatient utilization where shorter stays and/or outpatient treatments were practical. The understanding of both hospital and its physicians was if we improved the efficiency of hospital operations, we would retain the savings as the DRG incentive was structured.

The net effect of this cost management plan has been dramatic. In the three years that Humana Hospital-Daytona Beach has been on the PPS system, average length of stay for medical/surgical admissions has declined 15% annually. DaySurgery admissions (partly converted from more costly inpatient stays) have increased by more than 100%. In spite of a severe statewide nursing shortage, the utilization of expensive nursing agencies to supplement inhouse staff has decreased from 5,553 nursing hours in 1986 to zero in all of 1988. And physician DRG compliance has been so outstanding the hospital has been placed on the most minimal PRO review (3%) permitted under Medicare regulations. The hospital and its physicians have clearly kept their side of the bargain. And yet, the hospital's net operating margin on Medicare patients declined from +6.5% in 1986 to -1.9% in 1988 due to negative and unfair payment trends (See Fig. 2),[6] while its total profit margin was reduced by nearly 50% primarily as a result of the Medicare impact.

The hospital's parent corporation, Humana, is the financial guarantor of health care for over 140,000 senior Floridians through the several Medicare products of its Group Health Division. Having acquired the insolvent I.M.C. Medicare Plan in south Florida, the new management has restored solvency, financial efficiency, and medical integrity to the plan. Chief among Humana's strategies in this successful endeavor has been the guarantee of reasonable reimbursement to the physician providers participating in the system.

In reference to Humana's business expansion into the role of insuror, David A. Jones, Humana chairman, stated: "We're trying to earn the trust and loyalty of

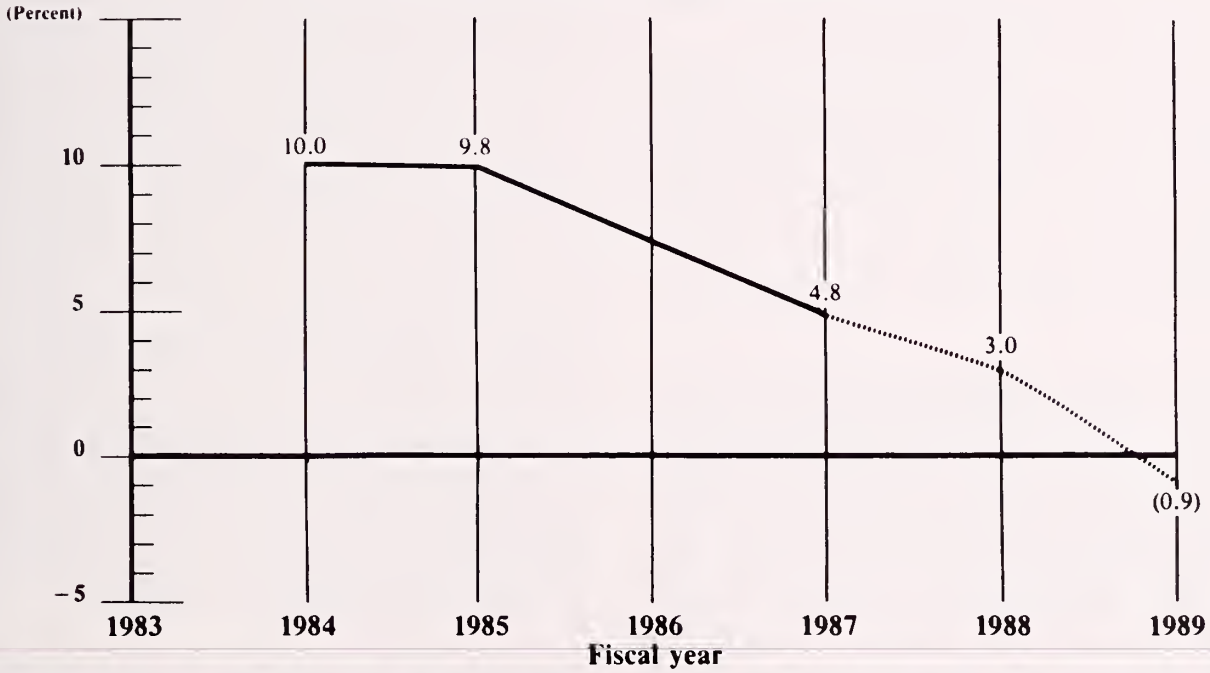
Medicare Payments to Hospitals Aren't Keeping Up With the Cost of Providing Quality Care



(E) = estimated

*Hospital Market Basket represents the costs hospitals must pay for goods and services, such as nursing, equipment, mortgage, utilities, etc.

Hospital Medicare Operating Margins



Source: Consolidated Consulting Group, Washington, D.C.

Hospitals receiving the minimum 1% DRG increase for FY 1988-89, will lose 1¢ for every $1.00 received from Medicare for inpatient cases in 1989.

(Projected margins are based on total Medicare payments and costs.)

Figure 2.

physicians by helping them be successful, so that they feel really good about their ability to provide high quality medical services to their patients."[7] This experience should have broader application to Medicare fiscal policy: health care providers can deliver efficiency as well as quality with incentives that reward, rather than penalize, quality medical care and hospital service.

Impact on physician practice ● The medical practice of physicians is impacted in two ways by shortfalls in Medicare reimbursement. On the hospital side, the quality of hospital practice is linked directly to the financial viability of the hospital industry in general, and the physician's local hospital in particular. The quality and stability of staffing, the availability of needed supplies and equipment, and the hospital's commitment to full service delivery all affect the bottom line effectiveness of the curing process. When hospitals are underfunded, physicians, and the patients they serve, are shortchanged.

On the office practice side, Washington is now considering a series of proposals aimed at reducing Medicare physician payments in reaction to increased Part B payments and premiums. Since 1980, Part B premiums have increased 258%. The government, however, itself encouraged this trend by moving patients from hospitals to outpatient services and physician offices, resulting in a two-day reduction of hospital length-of-stay. Therefore, Medicare Part B participation is bound to rise, and is rising by 500,000 patients per year. Thus, by increasing Part B demand and decreasing Part B reimbursement, these proposals will only compromise the physician rather than actually doing something about the cost.[8]

Additionally, some legislators want to require all physicians who care for Medicare patients to accept assignment, denying all patients and physicians the convenience and efficiency of rendering payment at the time of service, further increasing the real cost of business in the office practice. The only possible outcome of these proposals is a physician move away from Medicare and a subsequent curtailed access to care for the elderly.

Health care policy implications ● All health care providers should urge our elected officials to oppose any legislation that inadequately funds Medicare. Many responsible leaders are becoming aware of the growing hospital crisis. On September 28 a joint resolution was introduced in Congress by Senators Paul Simon (D-Ill.), Nancy Kassebaum (R-Kan.) and David Darenberger (R-Minn.) and Representatives Nancy Johnson (R-Conn.), Bill Oberstar (D-Minn.) and Barbara Boxer (D-Calif.) urging that Medicare funding in fiscal year 1990 not be reduced below the levels set forth in current law. The cosponsors noted that in each of the past several years, budget cuts have caused Medicare payments to lag well behind the cost of providing care. The resolution is "recognition of the crucial fact that an underfunded health care system cannot deliver the quality of health care that has been promised to the American people," said the executive director of the Federation of American Health Systems, Michael Bromberg. "We fervently hope it will mark an awakening on the part of Congress that this commitment must be renewed."[9]

Because the current congressional session ended last week, Senate Joint Resolution 387 is largely symbolic. However, the resolution will be introduced again in January 1989. The remainder of calendar year 1988 is an opportune time to contact all Florida congressional representatives to request them to cosponsor this resolution and then fight for its passage. Although this resolution is nonbinding, the willingness of our representatives and senators to cosponsor this legislation will be a clear statement of whether they are for or against Medicare cuts.

The health care industry also confronts a new treat in the form of a congressional bill (HR 5257) introduced by Fortney Pete Stark (D-Calif.), chairman of the House Ways and Means Health Subcommittee. "Decisions about hospital care are not ones which should be closely held in the powerful hands of administrators, doctors, or trustees," Mr. Stark stated in his introduction to the U.S. House of Representatives. His proposal would tie Medicare capital reimbursement to a plan required of each state that would enable a separate state review body to identify hospitals and parts of hospitals which should be closed, based on occupancy levels. Not only is the intent of this bill to further reduce Medicare reimbursement to hospitals for legitimate needs, but it is also to transfer hospital management prerogative to a whole newly created level of national bureaucracy, the cost of which is not even determined or addressed in the bill. The bill will be reintroduced in 1989.

For many reasons, consequently, the "Protect Medicare" resolution is becoming increasingly important. Thus far, only two Florida U. S. representatives have officially endorsed this resolution: Bill Grant (D-Fla.) and Bill Young (R-Fla.). Neither U. S. senator from Florida has yet committed to cosponsoring this legislation. Physicians in the state of Florida who are on Medical Staff Executive Committees or Governing Boards can help stimulate considerable public pressure by working with their hospital administrators to encourage all physician staff members, employees, and volunteers to write their Congressman in support of this important resolution. It could be our first step toward restoring stability to the deteriorating condition of the nation's Medicare program.

Conclusion ● The economics of health care poses a serious challenge that our communities and legislators can no longer ignore. While providers are under continued, and at times untenable, pressure to decrease overall health care utilization, the dollars

available for legitimate health care needs must not dip to a level where quality of care is sacrificed. Adequate provider reimbursement alone will not guarantee quality, but it is certain that inadequate reimbursement will guarantee deterioration of both access and quality in the health care system we know today.

References

1. Health Care News; Humana Public Affairs Dept, At Risk: The Health of our Nation, Louisville, KY.
2. Robin, Robert J.: Critical Condition, America's Health Care in Jeopardy, National Committee for Quality Health Care, Washington, D.C., p. vii, 1988.
3. Division of Cost Estimates, Office of the Actuary, Health Care Financing Administration, National Health Expenditures, 1986-2000, Health Care Financing Review 8 (4): 1-36, 1987.
4. Lewin/ICF, A Division of Health and Sciences Research, Inc., Analysis of CFA data.
5. Humana Public Affairs Dept., Louisville, KY.
6. Consolidated Consulting Group, Washington, D.C.
7. Wall Street Transcript, Volume 7, Number 12, December 1987.
8. U.S. Dept. of Health and Human Services, HCFA data.
9. Bromberg, Michael: Federation of Health Systems News, Washington, D.C., 1988.

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Daytona Beach

Uplifting the Physician's Devalued State of Mind

Doctors are becoming a congregation of depressives. Wander into a medical society meeting anywhere in the United States, and you will be chilled immediately by the despair and disillusionment so apparent in the voice tones and conversations of the members. The choruses of complaints are monotonous in their similarity, despite the geographic and sociologic differences of the physicians and their practices. Doctors feel cheated by the contrasts between the glowing promises of professional self-esteem, humanism and career independence that characterized medicine when they began their preparation for it and the current realities of medical practice.

Professional self-esteem has been subjugated by the legislative mandates that have curtailed our abilities to make scientific judgements on behalf of our patients; by the judicial removal of our rights to monitor and modulate the professional behavior of ourselves and any of our errant peers; and by a constantly nagging threat that any biologic misfortune that befalls a patient may enmesh us in a malpractice suit. Our willingness to deliver selfless and humanistic care is diluted by time-costly paper work that must be completed whenever we perform the slightest clinical service lest we fracture some occult regulatory statue.

Finally, the opportunity for any doctor to practice independently is vanishing. Mounting overhead costs, combined with attempts by insurance companies, HMOs and PPOs to squeeze reimbursement schedules, engenders doubt as to whether the independent practitioner will survive. Furthermore, public and political opinions (or other) that doctors are overpaid for their services and are the cause of the high economic burden of health care make many doctors actually feel guilty—a sensation that further numbs their already depressed state of mind.

The medical profession needs an injection of hope, a transplantation of pride, an infusion of awareness of our worth to society. Fortunately, the economic dark ages of medicine are behind us—when the real cost of illness was six to twelve times more expensive to the patient in terms of lost wages, shortened lives and household economic disruption than it is today. Fifty years ago doctors could offer the seriously ill patient kind words and comfort and a thread of hope that some miracle would intervene to save his or her life, preserve a limb or prevent crippling. Today, death and disability (and lost household income) due to coronary artery disease, arthritis, many types of cancer, trauma and birth defects, have been remarkably constricted by the application of the skills that physicians have acquired and apply in their everyday practice. We need to remind the public and the health care payers that medical care is an investment in society. The next time an insurance company balks at paying $1,800 for a cataract operation that will restore a patient's ability to see and drive and function independently, or $2,000 to an orthopedic surgeon for replacing a joint so that the patient will not have to consume $20,000 a year nursing home care, or $4,500 for a cardiovascular surgeon for replacing some plaque-encrusted coronaries so that a 58-year-old executive can return to work, earn an additional $500,000-$1,000,000 and collect a pension rather than becoming an unproductive member of society—remind them of these economic realities. The gross product of a nation is dependent upon the productivity of each and every one of its citizens. Even the medical care of a retired, elderly patient is economically productive in today's society—if appropriate medical care can permit the elderly individual to function independently—without nursing home care, or without the attention of a family member who could enter the job marketplace and earn dollars to support the family.

Despite the vast improvement in the economic productivity of medicine (as directed by physicians), society is attempting to curtail physician income; yet the inflation-adjusted incomes of the cognitive physicians are at their lowest levels in over a decade. This month some Volusia County physicians were approached by another HMO to care for their patients; the doctors would be granted this "privilege" if they offered the HMO a 15-20% discount from the normal fee schedule. My response to the inquiry was that I would work with them, but that they would not only eliminate the fee reduction but also would have to provide me with a 30% surcharge over my regular fees;

this surcharge is well deserved since it is dictated by the extra cost of doing business with the HMO. My staff would have to collect the deductible, perform extra paperwork, and waste time on the phone obtaining approval of patient's hospital admissions and other services. I would have to withstand the cash flow problems that accompany the inevitably delayed payments by the HMO. The HMO would use my name in its advertising to recruit other physicians and patients, thereby increasing its own revenue. Furthermore many HMOs suffer, or rapidly develop fiscal asthenia (as we know too well in Volusia County). Any doctor who signs with an HMO assumes the risk of HMO bankruptcy and loss of reimbursement for a significant amount of service rendered. The added administrative expense, increased risk, and marketing exploitation of the doctor's name makes a 30% surcharge a bargain to the HMO. Physicians settling for less practice financial self-immolation.

It is ironic and sad that American organized medicine is under financial attack at the time in its existence when its contribution to the economy is the greatest. Societies that sustain the physician in high esteem, such as Japan and Western Germany, are economically flourishing, while countries that have denigrated their physicians, such as Great Britain, Russia, and the Eastern bloc countries, have economically stagnated and declined. One of the most important supports to any economy is the physical health of its people and, like any resource, this must be maintained and improved. A well-respected, highly-educated and highly-motivated medical profession is needed for that task.

We physicians measure our self-worth by our hard work, extended hours, continual intellectual growth, sense of caring, and by the technologic magic which we apply for the betterment of our patients. Tragically, society has come to measure our worth in fiscal terms. Medicine, however, has succeeded remarkably well in economic terms. During the last decade the total cost of illness (which includes the direct cost of medical care plus the indirect costs imposed by lost wages and job productivity) has actually increased for the citizenry less than 70 years of age—despite the significant rise in health care costs! We need to recognize, take pride in, and publicize the economic value we add to our patients and their families, and ultimately to the nation's economy. Since we are economically productive we need not feel guilt about requesting fees for our services, nor should we fatalistically agree to fee curtailments imposed by outsiders. Most importantly, we need to broadcast to our patients and society's leaders the economic value of medical care. Rather than passively accepting the blame for the "high" cost of medical care, we need to take more credit for reducing the cost of illness to people and for the high return on investment of income that good medical care returns to the productivity of the citizens who use it. Medicine is a societal resource, not a societal burden.

Jacques R. Caldwell, M.D.
Editor of The Stethoscope

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Doctors that Patients Love to Hate

Have you ever wondered why patients love their own physicians but hate doctors in the aggregate? Poll after poll confirms this physician-patient paradox. When research is done on this subject, the studies being reviewed must be divided into those in which patients were asked about their own physicians and those in which they were asked about physicians as a group. Usually, positive feelings about the medical profession trail behind those for their patient's own physician.

Each year the American Medical Association measures the satisfaction that patients experienced with their most recent physician visit. The items measured include behavior of the office staff, willingness of the physician to explain, length of wait to get an appointment, and quality of medical care. Patient satisfaction in these areas has shown significant improvement since the surveys began in 1978. The improvement has been attributed, in part, to the increase in the number of physicians, which has resulted in more time spent with patients, less waiting in the office, and more time spent explaining conditions and treatments to patients.

These studies shed new light on the dynamics of patient satisfaction. In shopping for a physician, length of wait for an appointment is more important than fees, office hours, parking, or advertising. The office staff's behavior helps determine whether a patient will stick with a physician. Patients, according to the latest survey, do not believe that doctors are much smarter than laypersons. Because of this, patients feel that they are perfectly able to judge a doctor's competence. They do not think that advertising influences their selection of a physician. Whether a

patient will return and stick with the physician appears to depend on whether the patient's and the physician's personalities mesh.

At some time or another, almost 40% of Americans have stopped going to their doctors or have switched doctors because they are dissatisfied. In a Harris poll of 2,500 Americans, many patients felt that their physicians did not spend enough time with them. The poll suggested that "people like to get what they pay for" and that personal attention from their physician is an important priority.

Primary care physicians, who fared better in the survey than specialists, are perceived as the doctors who treat patients not as pieces of machinery that are broken but as living beings. Depersonalization appears to be what patients complain most bitterly about.

Some studies reveal rather interesting shifts in public expectations for medical care. For example, patients lay the blame for high medical costs first on hospitals, then on physicians, and then on drug companies. While patients accept somewhat higher charges from their own physicians, they think fees in general are too high. Another disturbing finding is the widespread opinion that the medical profession generally is too interested in making money.

There are three areas in which patients are rigid. They want access to advanced technology, they want to reserve the right to sue (they feel this is the only retribution available), and they do not want to wait for an appointment. Every survey shows that the length of time a physician spends with a patient is the key to patient satisfaction. Second in importance in the patient's eyes is the amount of information a physician provides.

As competition heats up all around us, there are some simple things we can do to develop more loyalty in our established and new patients. These things, in general, have nothing to do with how up-to-date or scientific our care is. In 30 years of clinical practice, I have not had one patient ask me what my class standing was in medical school. Loyalty has much more to do with what used to be called bedside manner—the art of medicine, if you will. For some physicians, it may spell the difference between financial success and lean times. In no way am I suggesting that scientific medical knowledge be diminished in importance, only that it be accompanied by compassionate, prompt care.

I am sure you all have your unique ways of accomplishing these goals. I make it a point to sit down with each patient at some time during the visit. I listen intently and look directly at the patient. We all have a number of these techniques that have proved effective over time. Although only a few extra seconds may be added to the visit, patients perceive that I spend considerably more time with them.

Patients have been well educated by television (their chief source of health information) to expect all the advanced technology ever designed, and they further expect their physician to be master of it all. So what is the bottom line for practicing physicians? We are living in a period of dramatic change, and we have only vague guideposts by which to set our course. If you are looking for definite solutions, forget it. There aren't any. We have to develop them as we go along. There will be bumps and bruises along the way, but faith in the basic precepts of medical practice will continue to serve as a sound basis for our actions.

So now if you wish to join the "doctors patients love to hate" fraternity, here are some things you might do:

- Make patients wait two weeks or longer for an appointment.
- Allow your staff to be rude and snippy with patients.
- Impress upon your patients how much smarter you are than they are.
- Grumble about your finances, and bad-mouth the greedy lawyers in front of all your patients.
- Spend as little time as possible with each patient. Make your visits very scientific and clinical and use impressive medical terms.
- Don't waste time explaining what is wrong. Just say, "Take these pills and see me in a week—goodbye."

J. Mostyn Davis, M.D.

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INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association, Inc. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussion of medical history and ethics; and articles dealing with socioeconomics, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to R.G. Lacsamana, M.D., Editor of *The Journal of the Florida Medical Association, Inc.*, P.O. Box 2411, Jacksonville, FL 32203, in original and three duplicate copies.

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Manuscript Style: Copies should be typewritten and double spaced. Each of the following should begin on a new page: Title page (which should include author information), abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page after the title page should include a running head and surname of lead author and be numbered consecutively.

Titles should be short, specific, clear and amenable to indexing. Titles should not exceed 80 characters, including punctuation.

Author Information: List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given. The mailing address of the lead author should be included.

Abstract: All scientific manuscripts must include an abstract of not more than 150 words. The abstract is a factual (not descriptive) summary of the work which replaces the summary and precedes the articles.

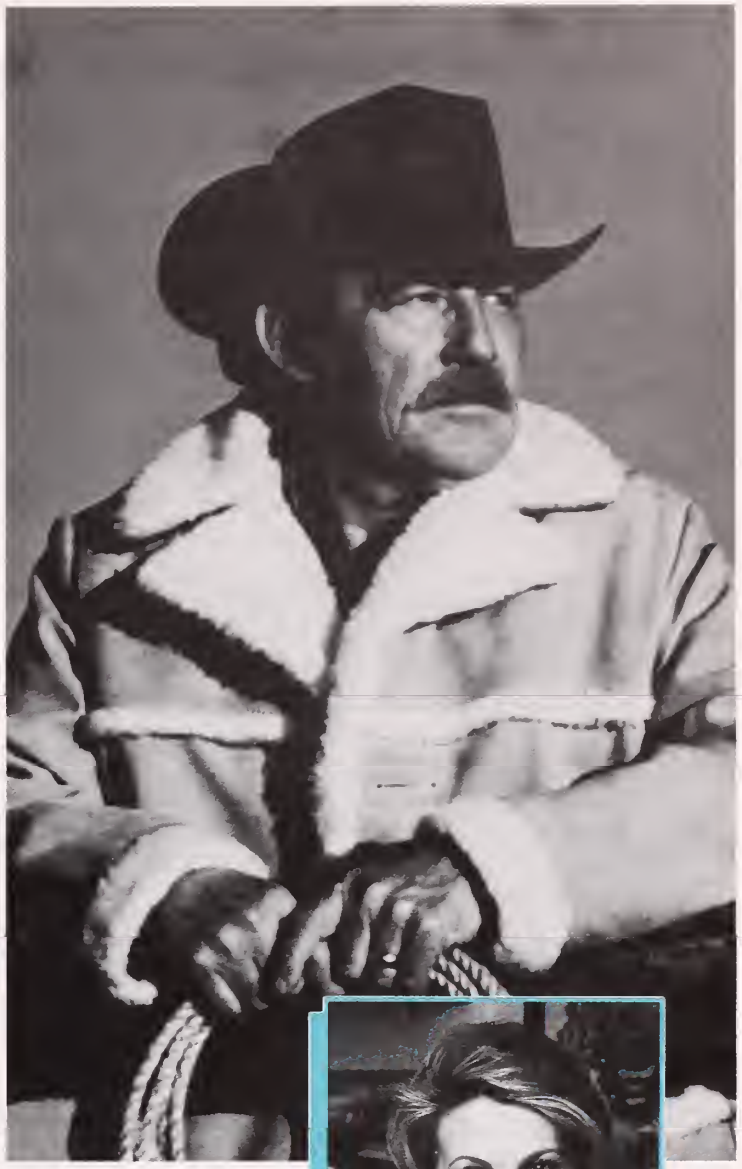
References: The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If the references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request."

Illustrations: Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of the illustration: figure number, title of manuscript, name of author and arrow indicating the top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with I. Each table must have a short title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the lead author will be sent an acknowledgment of receipt and a copyright agreement which MUST be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.



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AVIS

Auxiliary Liaison Editor — **Mrs. Donald (Renee) Winkler**

Partners in Practice: The Art of Interdependency

A plethora of literature has described the pressure inherent to medical training and its deleterious effects on the trainee's interpersonal relationships. This comes in an era of changing attitudes based on expectations of greater interpersonal rewards from marriage, family, and friendships. Society's once held tenet of work as a predominant means of gratification has given sway to the position, "you can have it all." I challenge this latter belief on the basis that most individuals who are driven to fit it "all" in eventually self-destruct. I agree, however, that placing emphasis on lifestyle balance is critical. In reality, striking that balance can be a most difficult endeavor.

It has been said that graduating physicians of today live by an ethic wherein they expect to be excellent in their field, *and* enjoy an abundant life outside medical practice. Research indicates a fast disappearance of the image that patient care preempts family needs. A resurgence of information on fundamentals of interpersonal closeness has followed.

Allow me to suggest that central to the effectiveness of a medical student marriage or relationship is a proper sense of balance between autonomy and dependency. This issue is of particular significance in relationships during medical training years, as this is the time when the stage becomes set. It is the training ground for medical practice coupled with medical relationships. Psychologists have long realized that successful resolution of the dependence/independence conflict in adolescent development is imperative (a concept often referred to as separation/individuation). I purport that in the course of a medical relationship this issue also prevails. Rather than expressing itself in the context of a parent/child relationship, it must now be worked through the adult/adult relationship.

In effect, there has to be sufficient room for both interpersonal and personal growth such that each partner feels neither squelched nor abandoned by the other. The solution is one of relating to each other in an interdependent fashion, where the "whole" of the couple is greater than the "sum" of the two individuals. When a couple reaches interdependent balance, this property serves to undergird and cement the relationship amidst the ebb and flow of medical training with its unpredictable schedules, extended work hours, and need for spontaneity. When the scale is tipped towards excessive dependence and/or independence on the part of one or both partners, the relationship may be headed for future collapse.

A familiar scenario depicting the lack of balance might be that of the overtaxed physician-in-training and his or her "neglected" partner. Visualize the physician-in-training as a strong silent type (often self-selected for surviving the throes of medical school), and the partner as a highly emotionally charged individual. Paradoxically enough, these personality profiles are often drawn to one another. Add to this, a disparity in communication styles, with the former individual being "bottom line," straight to the point, and the latter, a detail-oriented conversationalist. Not only will this couple talk past one another, but they are, for all intents and purposes, speaking different languages. One leans inward for fulfillment of personal needs, the other leans outward.

This dynamic continues to fuel and thus perpetuate itself. The one partner makes efforts to individuate from what they perceive to be a stifling and sometimes toxic relationship. They respond with passive-disdain when they see their individuality being jeopardized. The other, incensed that emotional needs are not being satisfied through the relationship, intensifies efforts to bolster the interpersonal bond; they may express resentment and bitterness in a passive-aggressive manner. Disaster lurks.

This particular vignette is purposefully overstated and is not suggestive of all or even most medical relationships. It is simply being used as an extreme example to portray the dependence/independence dilemma. Other less than functional relationships indentified in the literature include the enmeshed, symbiotic, dependent couple and the highly competitive, separate but equal, dyad. These all represent classic struggles from which major marital or interper-

sonal problems inevitably result, eventually leading to the disintegration of the "tie that binds" and a relationship that cracks under the strain. It is possible to achieve interdependent balance in a relationship by resisting the temptation to pull into the walls of any one person and/or thing with the expectation that one's needs will be met entirely by same.

An individual attains interdependent balance by acknowledging a need for others. Far from self-sufficiency, humans are designed as interdependent beings, made to live relationally. A person must allow herself or himself to become intertwined with a variety of individuals (one's spouse, colleagues, friends), and with activities (occupation, religion, recreation, etc.). As one establishes these interconnections, meaningful and enriching experiences will be fostered and one's needs can be met. Fine-tuning the art of interdependency, a concept which presupposes one's need for another, eventually results in committed partnerships of depth and lifetime endurance. By thrusting one's self into medical and family life with a renewed sense of vigor and with a healthy balanced perspective which overlooks the "unresolvables," one may dodge both the obstacles of oppressive dependence and excessive independence.

Mrs. Peter (Nancy) Cole
Miami

Mrs. Cole, a family therapist in Miami, is chairman of the AMA Medical Student Section Auxiliary, University of Miami School of Medicine. Her husband is a third year medical student there.

Our Apologies

Last month's "FMA Auxiliary" page listed Mrs. Charles (Lynn) Moore as the Auxiliary Liaison Editor. Since the September Annual Meeting, Mrs. Donald (Renee) Winkler has been the Auxiliary Liaison Editor. We sincerely apologize to Mrs. Winkler for this oversight.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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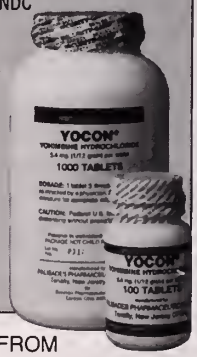

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ARMY RESERVE MEDICAL PROFILE NO.7

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
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Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%, genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
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Meetings

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JANUARY

Surgery of the Liver and Biliary Tract, Jan. 5-7, Alexander Hotel, Miami Beach. Contact: Duane G. Hutson, M.D. (305) 687-1367.

G.S. Wise Postgraduate Seminar of the Dept of Surgery, Jan. 5-7, Alexander Hotel, Miami Beach. Contact: W.T. Bouck (305) 687-1367.

12th Annual Oral Pathology Review, Jan. 7-11, Hyatt Regency, Miami. Contact: CME Department (305) 547-6716.

21st Annual Postgraduate Seminar in Adult & Pediatric Urology, Jan. 9-12, Intercontinental Hotel, Miami. Contact Charles M. Lynne, M.D. (305) 547-6630.

Seminar on AIDS and HIV, Jan. 10, Tampa. Contact: Unv. of S. Florida.

21st Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 10 & 12, Hotel Intercontinental, Miami. Contact: Victor A. Politano, M.D. (305) 687-1367.

Seminar on AIDS and HIV, Jan. 11, Clearwater. Contact: Unv. of S. Florida.

Pediatric Cardiology, Jan. 12, University Medical Center, Plantation. Contact: Dr. Richard Zackheim (305) 662-8301.

34th Annual Cardiovascular Seminar, Jan. 13-14, Manatee Civic Center, Bradenton. Contact: Melissa S. Crater (813) 867-5000.

Risk Management Seminar, Jan. 14, Medical Society, Pinellas County. Contact: (813) 541-1357.

Oculoplastic Update — 1989, Jan. 14-15, Good Samaritan Hosp., W. Palm Beach. Contact: Laura J. Lyons (407) 650-6236.

Magnetic Resonance Imaging, Jan. 16-20, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Diabetes Mellitus: Optimizing Treatment, Jan. 16-20, Jackson Medical Towers. Contact: Della Matheson, R.N. (305) 547-6504.

Pediatrics Care Network CME Program, Jan. 18, Univ. of Miami School of Medicine/Miami, FL. Contact: Dr. Nieves (305) 549-7600.

Topics in Pediatrics: 1989, Jan. 19-21, Lake Buena Vista Place, Orlando. Contact: Herbert Pomerance, M.D. (813) 974-4214.

Pediatric Practice Problems in Dermatology & Emergency Medicine, Jan. 23-25, Good Samaritan Hosp., West Palm Beach. Contact: Laura J. Lyons (407) 650-6236.

Tutorial Courses of Instruction in Acute Cardiac Care, Jan. 23-28, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Visiting Professor Series, Jan. 24-26, Miami. Contact: Penny Ripple (305) 547-6411.

Arrhythmias: Interpretation, Diagnosis and Management, Jan. 27-28, Boca Raton Resort, Boca Raton. Contact: Deborah Wilderson (305) 798-9682.

8th Annual Perspectives on New Diagnostic & Therapeutic Techniques in Clinical Cardiology, Jan. 27-29, Walt Disney World. Contact: Registration Secretary 800-253-4636.

Critical Care Medicine, Jan. 31-Feb. 1, Sheraton Royal Biscayne, Key Biscayne. Contact: Dept. of CME (305) 547-6716.

FEBRUARY

Strategies in Critical Care — 1989, Feb. 1-4, Sheraton Royal Biscayne. Contact: CME Department (305) 547-6716.

Drugs for the 90's, Feb. 3-5, Colony Beach Resort, Longboat Key. Contact: Thelma Bassett (305) 284-7350.

A.S.P.E.N.'s 13th Clinical Congress, Feb. ??????, Fontainbleau Hilton, Miami Beach. Contact: Karen MacFirland (305) 587-6315.

15th Annual Vail Conference in Anesthesiology, Feb. 4-11, Vail, Colorado. Contact: Sonja Auzier-Craythorne (305) 547-6411.

Pediatric Nephrology Seminar XVI; From Old to New Frontiers, Feb. 5-9, Sheraton Bal Harbour, Bal Harbour. Contact: Pearl Seidler (305) 549-6726.

Obstetric and Gynecologic Opetions: Update Ultrasound and Laser Technology, Feb. 6-8, Good Samaritan Hosp, West Palm Beach. Laura J. Lyons (407) 650-6236.

Magnetic Resonance Imaging, Feb. 6-10, University Diagnostic Institute, Tampa. Contact: Martin Silbiger, M.D. (813) 974-2538.

Neurological Update — 1989, Feb. 7-11, Sheraton Bal Harbour, Bal Harbour. Contact: Univ. of Miami School of Medicine/Div. of Cont. Ed. (305) 547-6716.

Midwinter Seminar in Obstetrics and Gynecology, Feb. 9-11, Don CeSar Beach Resort, St. Petersburg. Contact: Betty Monti (813) 974-2088.

14th Annual Vail Symposium in Intensive Care, Feb. 11-18, Vail, Colorado. Contact: Sonja Auzier-Craythorne (305) 547-6411.

Cardiopulmonary Rehabilitation, Feb. 13-16, Orlando. Contact: Michael Pollock, Ph.D. (904) 392-9575.

Pediatric Care Network CME Program, Feb. 15, Univ. of Miami School of Medicine/Miami, FL. Contact: Dr. Nieves (305) 549-7600.

AIDS Update 1989, Feb. 16-17, University Centre Hotel, Gainesville, FL. Contact: Grace Wagner (904) 392-3143.

Florida Thoracic Society's 11th Annual Pulmonary Wintercourse, Feb. 16-19, Contemporary Resort, Lake Buena Vista. Contact: Richard Doggett (904) 743-2933.

11th Annual Pulmonary Wintercourse, Feb. 16-19, Contemporary Hotel, Magic Kingdom. Contact: Florida Thoracic Soicety (904) 743-2933.

Pediatric for the Practitioner — Update on Intensive Care of Children, Feb. 17, Sheraton Tampa East, Tampa. Contact: Herbert H. Pomerance, M.D. (813) 974-4214.

Immunoconjugates Monoclonal Antibody Based Imaging, Feb. 17-19, Contemporary Resort, Walt Disney World. Contact: Dr. Aldo Serafini (305) 549-7955.

Current Status & Future Dir. of Imm. Mono. Ant. Based Imaging and Treatment, Feb. 17-19, Orlando. Contact: Division of CME (407) 547-6716.

Diagnosis & Management of Respiratory Diseases, Feb. 17-19, Sonesta Beach Hotel, Key Biscayne. Deborah Wilderson (305) 798-9682.

Eyelid Surgery: A Basic Course For the Practicing Physician, Feb. 18, Sheraton Grand Hotel, Tampa. Contact: J. Justin Older, M.D. (813) 971-3846.

14th Annual Review & Recent Practical Advances in Pathology, Feb. 20-24, Fontainebleau Hotel, Miami Beach. Contact: Marie Valdes-Dapena (305) 549-6437.

12th Annual Meeting of the American Society of Neruoimaging, Feb. 22-26, Grosvenor Resort Hotel, Orlando. Contact: Susan E. Syrstad (612) 378-7240.

University of Miami School of Medicine's Annual Conference — "Dementia; Current Research and Clinical Aspects", Feb. 24-25, Sheraton Bal Harbour, Bal Harbour. Contact: Raphael S. Good, M.D. (305) 549-7661.

Vascular Surgery, Feb. 26-28, Palm Beach Airport Hilton, West Palm Beach, FL. Contact: Laura J. Lyons (407) 650-6236.

Problem Oriented Approach to Vitreous Surgery II, Feb. 27-Mar. 1, Miami. Contact: Gaby Kressley (305) 326-6031.

MARCH

21st Teaching Conference in Clinical Cardiology, Mar. 1-4, Sheraton Bal Harbour, Miami. Contact: Michael Gordon, M.D., Ph.D. (305) 547-6491.

Breast Disease Update VI Seminar, Mar. 1-4, Hilton at Walt Disney, Lake Buena Vista. Contact: Mrs. Esther Cohen (305) 674-2311.

Infertility & Reproductive Endocrinology, Mar. 2-4, Key Biscayne. Contact: Betty Spurlock (202) 863-2541.

Advances and Improvements in Hernia Surgery, Mar. 2-4, Hyatt Regency, Miami. Contact: Arthur I. Gilbert, M.D. (305) 687-1367.

Diabetes Mellitus: Optimizing Treatment, Mar. 5-10, Jackson Medical Towers. Contact: Della Matherson, R.N. (305) 547-6504.

Tutorial Courses of Instruction in Acute Cardiac Care, Mar. 6-11, Univ. of Miami, Miami. Contact: Louis Lemberg, M.D. (305) 549-6411.

Int'l Pediatric Epilepsy Surgery Symposium, Mar. 8-10, Miami Children's Hosp., Miami. Contact: Michael Duchwny, M.D. (305) 662-8330.

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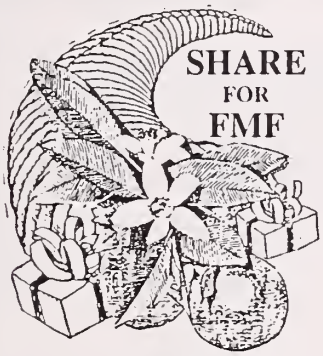

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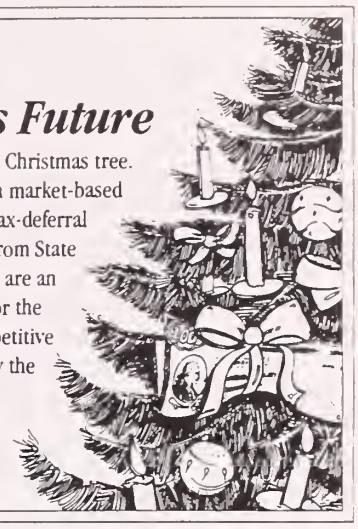

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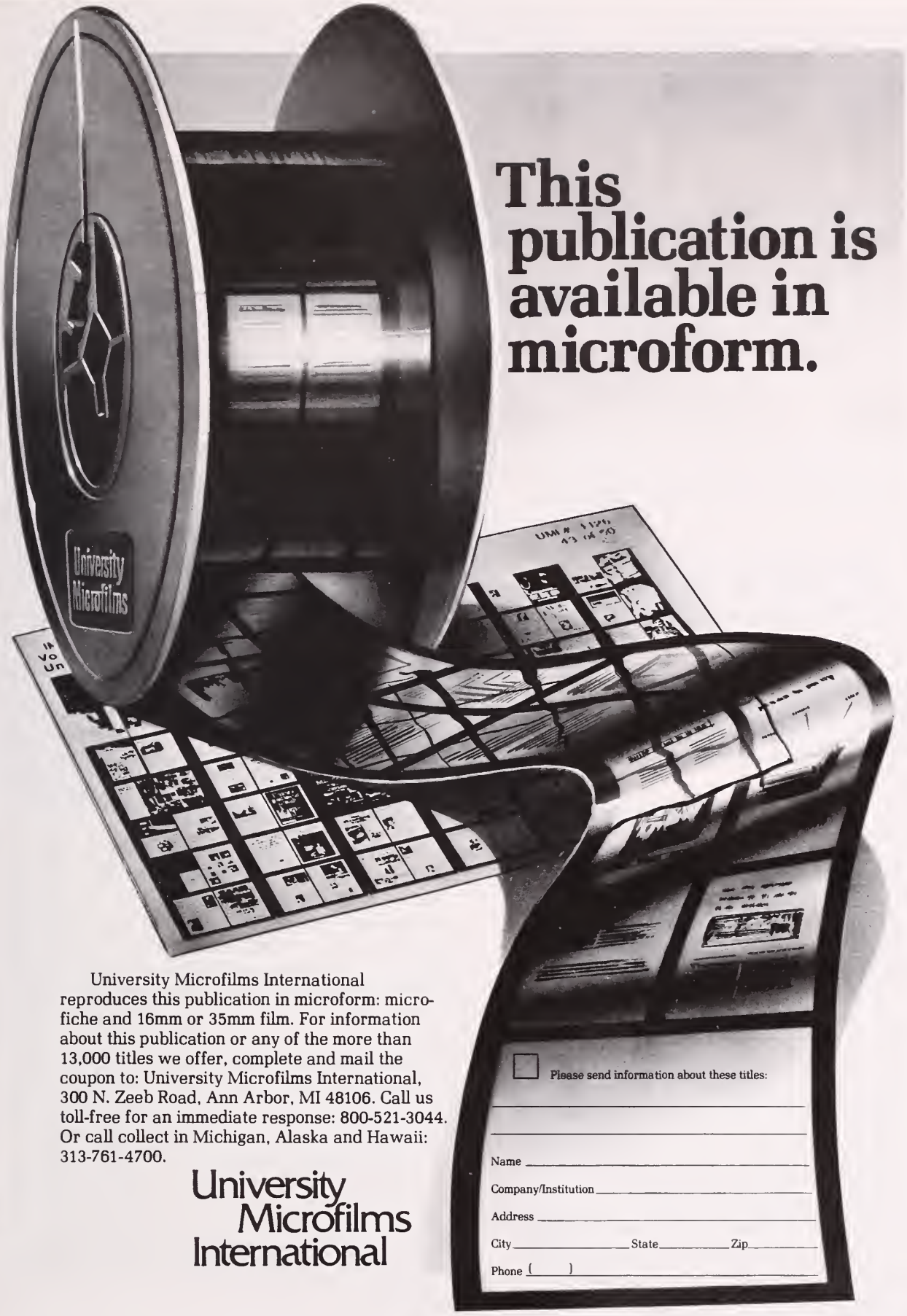

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Feature Editor — **Dale C. Havre, M.D.**

The Wizard-of-Oz Syndrome

How many of us have yellow brick roads leading to our offices? Is our attitude toward patients influenced by the "Wizard-of-Oz" syndrome? Several years ago my ophthalmologist friend, John Rowda, explained the features of this controversial syndrome to me. John is not sure whether he is the first to name the syndrome, but I shall be happy to give him credit until we hear otherwise.

To qualify as a wizard a doctor must believe that patients will be in awe of him or her if only they are kept from actually seeing the doctor for long periods of time. A skilled wizard places so many obstacles between himself or herself and a patient that the bewildered person, finally in the hallowed presence of this very busy and all-knowing being, will just nod in mute agreement to whatever the "Great One" has to propose.

Being a wizard is a relatively stress-free way to practice medicine. Always have somebody else take a history and listen to complaints. Better yet, let patients agonize over a multipage questionnaire in the waiting room and then blame them for incompletely filling out the form if something amiss develops in their diagnosis or treatment. Never, never check a blood presure yourself, look at a thermometer, or give an injection. To do such things is a sign of weakness, according to wizard mentality. It is certainly not cost effective to perform such easily delegated tasks personally and, worse yet, it will quickly tarnish the image of any self-respecting wizard.

A veteran surgeon-wizard will scrupulously avoid meeting with a patient outside the operating room. Preoperative counseling and postoperative care are anathema to surgeons in the Land of Oz. It ruins the mystique to be seen without a mask and greens on and, heaven forbid, one might actually have to answer a question or explain a procedure. Such lapses of protocol cut into operating time and surely will adversely affect the monthly gross. The serious wizard always has enough well-trained assistants to keep inquisitive patients at bay.

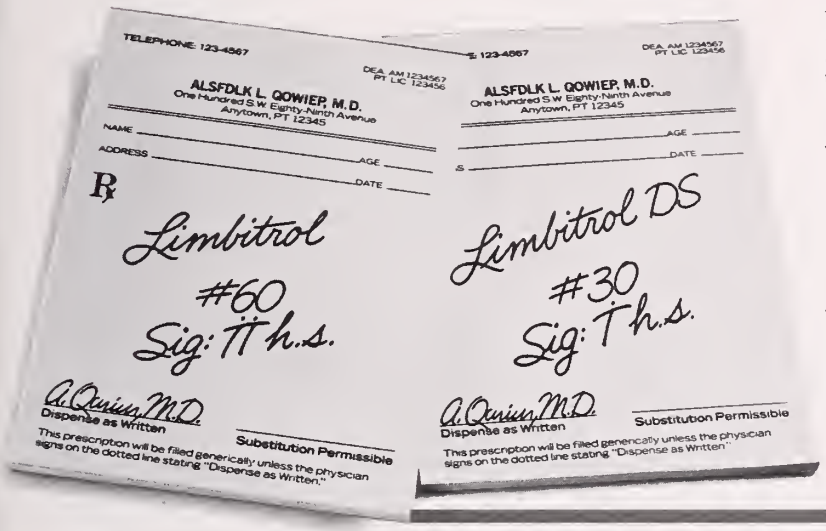
As a doctor it can be hazardous living around surgical wizards, because patients invariably will call you, instead of them, in the middle of the night about their postoperative problems. It seems they would feel guilty bothering the "he's-so-busy" wizard himself. After experiencing a few of these unpleasant nocturnal episodes, the "ordinary" doctor begins to discover what a pain this wizard really is. Unfortunately, a lot of patients never realize they have been loved and left by the Oz-based doctors.

One-procedure doctors seem especially suited for the Wizard-of-Oz syndrome. I have had patients describe the overwhelming hype and circumstances that can totally dominate their visit to such specialists' Oz lands. The process is so slick and distracting that they have found themselves signing up for an operation without ever meeting the surgeon. To reward their blind trust they hope to be treated to a successful surgery and will get an "attaboy" pat on the back as they leave the operating room; then, off to somebody else for follow-up care. If there are complications the wizard is seldom blamed because, after all, isn't he the best? Why, he's so good he did 75 earlobe tucks that day and if my earlobe is stil dragging on the ground, it must mean that I am an incurable case. That's the syndrome at its finest (worst?).

I hope all of us will take a look out our office windows to see if there is a yellow brick road leading into the parking lot. If there is, perhaps we should come down off our hidden perch in the consultation room and call the highway department at once. We could use a repaving job—fast. Patients will not innocently walk that yellow route much longer. They are beginning to recognize the hazards of brick roads and the shortcomings of wizards. Patients need to meet more real doctors, on real roads, right in their own hometowns.

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



Protect Your Prescribing Decision: Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓘⓥ

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol® Ⓘⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manufestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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In the depressed and anxious patient

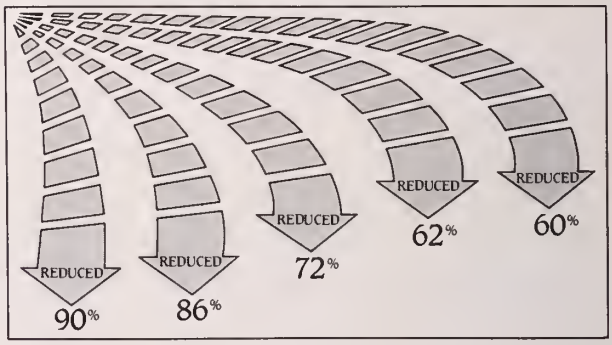
See Improvement In The First Week[1]...

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (IV)

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (IV)

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